Original

Bartlett ASC, LLC

CN1605-020

1. ***Name of Facility, Agency, or Institution***

Bartlett ASC, LLC
Name

0 Kate Bond Boulevard — Shelby
Street or Route — County

Bartlett — TN — 38133
City — State — Zip Code

2. ***Contact Person Available for Responses to Questions***

Kim H. Looney, Esq. — Attorney
Name — Title

Waller Lansden Dortch & Davis LLP — kim.looney@wallerlaw.com
Company Name — Email address

511 Union Street, Suite 2700 — Nashville — TN — 37219
Street or Route — City — State — Zip Code

Attorney — 615-850-8722 — 615-244-6804
Association with Owner — Phone Number — Fax Number

3. ***Owner of the Facility, Agency or Institution***

Bartlett ASC, LLC — _____
Name — Phone Number

8 Cadillac Dr. Suite 200 — Williamson
Street or Route — County

Brentwood — TN — 37027
City — State — Zip Code

4. ***Type of Ownership of Control (Check One)***

A.	Sole Proprietorship	_____	F.	Government (State of TN or Political Subdivision)	_____
B.	Partnership	_____			
C.	Limited Partnership	_____	G.	Joint Venture	_____
D.	Corporation (For Profit)	_____	H.	Limited Liability Company	X
E.	Corporation (Not-for-Profit)	_____	I.	Other (Specify) _____	_____

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

Response: Please see organizational documents included as Attachment A-4.

5. ***Name of Management/Operating Entity (If Applicable)***

USP Tennessee, Inc.
Name
15305 Dallas Parkway, Suite 1600 — Dallas
Street or Route — County
Addison — TX — 75001
City — State — Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

Response: Please see attached draft management agreement included as Attachment A-5.

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6. ***Legal Interest in the Site of the Institution (Check One)***

A. Ownership		D. Option to Lease	X
B. Option to Purchase		E. Other (Specify) _____	
C. Lease of _____ Years			

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

Response: Please see attached draft option to lease included as Attachment A-6.

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7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A. Hospital (Specify) _____		I. Nursing Home	
B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	X	J. Outpatient Diagnostic Center	
		K. Recuperation Center	
C. ASTC, Single Specialty		L. Rehabilitation Facility	
D. Home Health Agency		M. Residential Hospice	
E. Hospice		N. Non-Residential Methadone Facility	
F. Mental Health Hospital		O. Birthing Center	
G. Mental Health Residential Treatment Facility		P. Other Outpatient Facility (Specify) _____	
H. Mental Retardation Institutional Habilitation Facility (ICF/MR)		Q. Other (Specify) _____	

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8. ***Purpose of Review (Check) as appropriate--more than one response may apply)***

A. New Institution	X	G. Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	
B. Replacement/Existing Facility			
C. Modification/Existing Facility			
D. Initiation of Health Care Service as defined in TCA § 68-11-1607(4) (Specify) _____		H. Change of Location	
		I. Other (Specify) _____	
E. Discontinuance of OB Services			
F. Acquisition of Equipment			

9. **Bed Complement Data**

Please indicate current and proposed distribution and certification of facility beds.

Response: Not applicable

	Current Beds Licensed	Current Beds *CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A. Medical					
B. Surgical					
C. Long-Term Care Hospital					
D. Obstetrical					
E. ICU/CCU					
F. Neonatal					
G. Pediatric					
H. Adult Psychiatric					
I. Geriatric Psychiatric					
J. Child/Adolescent Psychiatric					
K. Rehabilitation					
L. Nursing Facility (non-Medicaid Certified)					
M. Nursing Facility Level 1 (Medicaid only)					
N. Nursing Facility Level 2 (Medicare only)					
O. Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P. ICF/MR					
Q. Adult Chemical Dependency					
R. Child and Adolescent Chemical Dependency					
S. Swing Beds					
T. Mental Health Residential Treatment					
U. Residential Hospice					
TOTAL					

*CON-Beds approved but not yet in service

10. **Medicare Provider Number** To be applied for
Certification Type ASC

11. **Medicaid Provider Number** To be applied for
Certification Type ASC

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid?** Yes

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants?** Yes **If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.*** AmeriGroup, BlueCare, United Healthcare Community Plan and TennCare Select
Discuss any out-of-network relationships in place with MCOs/BHOs in the area. N/A

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I. Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response:

Applicant/Ownership Structure: The applicant is Bartlett ASC, LLC, whose current member is USP Tennessee, Inc. ("USPT"). The parent company for these entities is United Surgical Partners International ("USPI"). USPI was founded in 1998, and is one of the prominent leaders in ambulatory surgery. USPI generally partners with physicians and health systems to own and operate ASTCs. In Tennessee, USPI, or a related entity, has an ownership interest in 22 ASTCS and 1 specialty hospital. A list of these facilities is included in Attachment B, Project Description, I-Executive Summary. Tenet purchased a controlling interest in USPI in 2015. As such, the structure of this ASTC is different than for those hospitals which are not owned by Tenet. In this situation, Saint Francis Hospital-Bartlett is not a direct owner of the Bartlett ASC, LLC. Instead, SFH-Bartlett will indirectly benefit from the establishment of this ASTC because the ultimate parent company of both Bartlett ASC, LLC and SFH-Bartlett is Tenet.

Facility/Services: The applicant proposes to establish a multi-specialty ASTC located on Kate Bond Road in Bartlett, approximately one mile from SFH-Bartlett. In Shelby County, there are 10 existing multi-specialty ASTCs. Two are owned by Campbell Clinic and limited to that physician group, one is owned by Semmes-Murphy and is limited to that physician group. The remaining ASTCs are all affiliated with an area hospital, including the Surgery Center of Saint Francis.

Service Area: The service area for the proposed ASTC includes portions of Shelby County as well as Fayette County. The zip codes that comprise the service area include 38134, 38002, 38135, 38016, 38133, 38128, 38053, 38127, 38068, 38060, 38018, 38122, 38019, 38004, 38058, 38011, 38108, 38028, 38023, 38049, and 38111. These zip codes are all included in the service area for SFH-Bartlett so it is reasonable to expect that an ASTC that is located in Bartlett would have a substantially similar service area. A map with these zip codes identified is included as Attachment C-Need-3.

Need: The applicant feels this project is needed based on several factors. The interest of Tabor Orthopedics, which is a group of 8 orthopedic specialists and 1 pain management specialist, is a very important factor, which accounts for a significant portion of the projected utilization. The fact that many of the surgeries currently performed at The Surgery Center at Saint Francis, Saint Francis Hospital and SFH Bartlett will be shifted to this surgery center, due to the type of surgery or convenience of the patients will also be key to the success of the Bartlett ASC.

Existing Resources: With the exception of North Surgery Center, which is located on the campus of and partially owned by Methodist North Hospital, there are no ASTCs in the entire proposed service area. North Surgery Center is generally used by those physicians who practice at Methodist North Hospital. Methodist closed its hospital in Fayette County in March, 2015. A significant number of those patients are choosing to receive care at SFH-Bartlett, which is the closest hospital.

Project Cost/Funding: The applicant anticipates leasing the ASTC space from a developer run entity for a period of 10 years. The overall project costs are estimated to be $9,815,770, which includes the net present value of the lease, the tenant improvements for the space, pre-opening expenses, working capital, and the equipment and furnishings necessary to operate the ASTC. Since the applicant will not be the entity owning and developing the project, there are no financing costs for the applicant.

Financial Feasibility: The project is financially feasible; the costs of the project are reasonable and the applicant expects to have a positive cash flow in year 2.

Staffing: The center will operate with 18.0 FTEs, 14.0 of which are clinical positions. Candidates are readily available from within the existing healthcare industry and the applicant's affiliated facilities. The center will utilize a number of channels to secure needed staff, including posting in on-line recruiting platforms and engaging recruiting firms. The applicant's affiliated facilities in Memphis have a history of successfully recruiting professional and administrative staff because they provide competitive compensation and benefits and are committed to the retention of existing personnel.

II. Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction

and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

Response:

The current member of the applicant, Bartlett ASC, LLC, is USPT. It is anticipated that USPT will own a 51% membership interest. The applicant also plans to syndicate 49% in membership interests to area physicians, including orthopedic surgeons and pain management specialists. Thus far, the applicant has received interest in ownership in the project from the physicians at Tabor Orthopedics. Tabor Orthopedics currently has 8 orthopedic surgeons and a pain management specialist. Tabor anticipates adding another pain management specialist in the next year and one or two more orthopedic surgeons over the next couple of years, which will significantly increase the group's surgical volume. With both orthopedic and spinal cases, and pain management services currently anticipated and the potential for other specialties, the applicant is requesting a CON for a multi-specialty ASTC.

The applicant plans to lease space from a developer for a newly constructed ASTC with 2 operating rooms and 1 procedure room, on a campus that will also include a MOB. To plan for anticipated growth in volume, due to both the growth in population in Bartlett, the addition of new physicians to Tabor Orthopedics, and the possible addition of other specialties, the applicant plans to have an additional operating room ready to use, but will not purchase equipment to make it operational until the utilization has increased sufficiently at the facility to justify its use. The facility will include pre-op and post-op space as well as waiting areas and all other required areas. The square footage will be approximately 13,500 square feet. The operating and procedure room spaces will be built to AIA Guidelines and State licensure standards for ASTCs. The cost per square foot for the new construction is anticipated to be $228.50 per square foot. The 2012-2014 third quartile statewide construction cost for ASTCs was $174.88 per square foot. However, recent projects such as the Southern Hills Surgery Center, CN1411-047D, had a higher construction cost at $360 per square foot. Thus, while the cost per square foot is higher than the cost per square foot calculated by the HSDA, it is lower than the cost per square foot projected for the Southern Hills Surgery Center, which the HSDA denied.

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response: Not applicable.

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Renovated	New	Total	Renovated	New	Total
B. Unit/Depart. GSF Sub-Total										
C. Mechanical/ Electrical GSF										
D. Circulation/ Structure GSF										
E. Total GSF										

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. Rehabilitation Services
21. Swing Beds

Response: Not applicable

D. Describe the need to change location or replace an existing facility.

Response: Not applicable. This application does not involve a change of location or replacement of an existing facility.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

1. For fixed-site major medical equipment (not replacing existing equipment):

   a. Describe the new equipment, including:

      1. Total cost ;(As defined by Agency Rule).
      2. Expected useful life;
      3. List of clinical applications to be provided; and
      4. Documentation of FDA approval.

      Response: Not applicable

   b. Provide current and proposed schedules of operations.

Response: Not applicable

2. For mobile major medical equipment:

   a. List all sites that will be served;

   b. Provide current and/or proposed schedule of operations;

   c. Provide the lease or contract cost.

   d. Provide the fair market value of the equipment; and

   e. List the owner for the equipment.

   Response: Not applicable

3. Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

   Response: Not applicable

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which **must include**:

1. Size of site (***in acres***);
2. Location of structure on the site; and
3. Location of the proposed construction.
4. Names of streets, roads or highway that cross or border the site.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

Response: Please see a copy of the plot plan included as Attachment B, Project Description-III.(A)-4.

(B) 1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response: The proposed site is on Kate Bond Rd, one block off of Highway 64 in Bartlett, Tennessee. The site is less than a mile from Saint Francis Hospital-Bartlett. Memphis Area Transit Authority operates the Wolfchase bus route on Highway 64. The route provides regular daily service. This route connects with other bus service throughout the Memphis area. Due to patient discharge policies, however, bus and taxi access is not advisable. Patients generally arrive and leave via private automobile.

The location is also very accessible by car. The proposed site is less than two miles off of Interstate 40. The location is between Highway 64 and Highway 79, both of which are major thoroughfares in Bartlett, providing easy access to the community.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

NOTE: ***DO NOT SUBMIT BLUEPRINTS.*** Simple line drawings should be submitted and need not be drawn to scale.

Response: Please see a copy of the floor plan included as Attachment B, Project Description-IV.

V. For a Home Health Agency or Hospice, identify:

1. Existing service area by County;

   Response: Not applicable.

2. Proposed service area by County;

   Response: Not applicable.

3. A parent or primary service provider;

   Response: Not applicable.

4. Existing branches; and

   Response: Not applicable.

5. Proposed branches.

   Response: Not applicable.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper*. All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

   a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

   b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)

AMBULATORY SURGICAL TREATMENT CENTERS

The Health Services and Development Agency (HSDA) may consider the following standards and criteria for applications seeking to establish or expand Ambulatory Surgical Treatment Centers (ASTCs). Existing ASTCs are not affected by these standards and criteria unless they take an action that requires a new certificate of need (CON) for the establishment or expansion of an ASTC.

These standards and criteria are effective immediately as of May 23, 2013, the date of approval and adoption by the Governor of the State Health Plan changes for 2013. Applications to establish or expand an ASTC that were deemed complete by the HSDA prior to this date shall be considered under the Guidelines for Growth, 2000 Edition.

Assumptions in Determination of Need

The need for an ambulatory surgical treatment center shall be based upon the following assumptions:

1. Operating Rooms

   a. An operating room is available 250 days per year, 8 hours per day.

   Response: The operating rooms will be available 250 days per year, 8 hours per day.

   b. The estimated average time per Case in an Operating Room is 65 minutes.

   Response: The applicant anticipates that the average time per case in an operating room will be 90 minutes, rather than the standard of 65 minutes.

   c. The average time for cleanup and preparation between Operating Room Cases is 30 minutes.

   Response: The applicant anticipates that the average time for cleanup will be 15 minutes rather than 30 minutes so the overall time for cases in the operating rooms projected by the applicant is the same as the criteria for operating rooms.

d. The optimum utilization of a dedicated, outpatient, general-purpose Operating Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 95 minutes 884 Cases per year.

Response: The applicant anticipates that it will meet the standard of 884 Cases per year in the second year of operation.

2. Procedure Rooms

a. A procedure room is available 250 days per year, 8 hours per day.

Response: The procedure room will be available 250 days per year, 8 hours per day.

b. The estimated average time per outpatient Case in a procedure room is 30 minutes.

Response: The applicant anticipates that the average time per outpatient Case in a procedure room will be 30 minutes.

c. The average time for cleanup and preparation between Procedure Room Cases is 15 minutes.

Response: The applicant anticipates that the average time for cleanup and preparation between procedure room Cases will be 15 minutes.

d. The optimum utilization of a dedicated, outpatient, general-purpose outpatient Procedure Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 45 minutes = 1,867 Cases per year.

Response: The applicant anticipates meeting the standard of 1,867 cases per year in year 3.

Determination of Need

1. Need. The minimum numbers of 884 Cases per Operating Room and 1,867 Cases per Procedure Room are to be considered as baseline numbers for purposes of determining Need. An applicant should demonstrate the ability to perform a minimum of 884 Cases per Operating Room and/or 1,867 Cases per Procedure Room per year, except that an applicant may provide information on its projected case types and its assumptions of estimated average time and clean up and preparation time per Case if this information differs significantly from the above-stated assumptions. It is recognized that an ASTC may provide a variety of services/Cases and that as a result the estimated average time and clean up and preparation time for such services/Cases may not meet the minimum numbers set forth herein. It is also recognized that an applicant applying for an ASTC Operating Room(s) may apply for a Procedure Room, although the anticipated utilization of that Procedure Room may not meet the base guidelines contained here. Specific reasoning and explanation for the inclusion in a CON application of such a Procedure Room must be provided. An applicant that desires to limit its Cases to a specific type or types should apply for a Specialty ASTC.

Response: The applicant anticipates having 2 operating rooms and 1 procedure room in the ASTC. Once the ASTC is fully operational, the applicant anticipates that the ASTC will perform over 3,200 cases per year. The applicant anticipates that the average surgical case will take 1 hour and 30 minutes and the average procedural case such as a pain management epidural procedure takes 30 minutes. The room turnover for both types of cases is expected to take 15 minutes. The applicant anticipates initially performing orthopedic, spinal, and pain management procedures. The orthopedic and spinal procedures will be performed in an operating room and the pain management procedures will be performed in a procedure room. The pain management procedures are anticipated to take less time than the procedures performed in the operating rooms and for the sake of cost and efficiency, for both the ASTC and the patients, it is important to have a separate procedure room in which they can be performed.

The number of cases projected for the first year of operation is 1,230 surgical cases, and 755 pain management epidural procedures for a total of 1,985.

For the second year of operation, the applicant projects 1,993 surgical cases and 1,224 pain management epidural procedures for a total of 3,217.

Although the applicant anticipates that the amount of time its cases will take is longer than the current ASTC standard - 90 minutes as compared to 65 minutes, it also expects that its turnover between cases will be less - 15 minutes versus 30 minutes, so the amount of time per case including turnover time is the same as the ASTC standard.

According to the CON Guidelines, the optimal utilization for operating rooms is 884 cases per room and for procedure rooms it is 1,867 cases per room. With a projection of 1,993 cases for the 2 operating rooms in year 2, the applicant anticipates exceeding the guideline of 884 cases per room in the 2nd year of operation. For the procedure room, the applicant anticipates performing 1,224 procedures or approximately 66% of the Guideline, and anticipates that it will meet or exceed the Guideline in year 3 of operation..

2. Need and Economic Efficiencies. An applicant must estimate the projected surgical hours to be utilized per year for two years based on the types of surgeries to be performed, including the preparation time between surgeries. Detailed support for estimates must be provided.

Response: The applicant anticipates providing orthopedic, spinal and pain management procedures. In the first year of operation, the 1,985 projected cases are estimated to require 2,907 hours of surgical time. In the second year of operation, the 3,217 projected cases are estimated to require 4,712 hours of surgical time. These estimates are derived from the following assumptions: the average surgical case takes 1 hour 30 minutes, the average procedural case such as a pain management epidural procedure takes 30 minutes, and room turnover for each case takes 15 minutes.

Projected Surgical Hours

	Year 1			Year 2		
	Cases	Time/Case	Total Hours	Cases	Time/Case	Total Hours
Projected Surgical Cases	1,230	1:30	1,845	1,993	1:30	2,990
Projected Pain Mgmt Cases	755	0:45	566	1,224	0:45	918
Total Cases	1,985	0:15	496	3,217	0:15	804
Total Time in Hours			2,907			4,712

3. Need; Economic Efficiencies; Access. To determine current utilization and need, an applicant should take into account both the availability and utilization of either: a) all existing outpatient Operating Rooms and Procedure Rooms in a Service Area, including physician office based surgery rooms (when those data are officially reported and available) OR b) all existing comparable outpatient Operating Rooms and Procedure Rooms based on the type of Cases to be performed. Additionally, applications should provide similar information on the availability of nearby out-of-state existing outpatient Operating Rooms and Procedure Rooms, if that data are available, and provide the source of that data. Unstaffed dedicated outpatient Operating Rooms and unstaffed dedicated outpatient Procedure Rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.

Response: All of the existing multi-specialty ASTCs in Shelby County are either affiliated and limited to a particular physician practice, or part of another hospital system. There are no existing ASTCs in Bartlett. The only ASTC in the service area is North Surgery Center, which is located on the campus of Methodist North. Bartlett is the 12th largest city in the State of Tennessee and the 2nd largest city in Shelby County. According to the Memphis Chamber of Commerce, Bartlett is one of the fastest growing suburbs in Shelby County. Based on U.S. Census data, Bartlett's population grew by 6.7% between 2010 and 2014, whereas Shelby County as a whole grew by only 1.1% during the same period.

Saint Francis Hospital added the Surgery Center of Saint Francis on its campus about ten years ago, which was after most of the other hospitals in Shelby County had added ASTCs to their campuses. SFH-Bartlett has been open for 12 years, and at the request of some of its doctors, the applicant is applying for the Bartlett ASC, LLC. Certainly, this speaks to an orderly progression of the addition of outpatient surgical services. The cost for outpatient surgeries performed in an ASTC is generally less than the cost in an acute care hospital, which is a benefit for patients. In addition, outpatient surgeries performed in an ASTC are considered to be performed in a less restrictive setting, which is also a benefit, particularly for patients from the more rural areas, and elderly patients, who may have difficulty navigating a hospital campus.

As can be seen in the utilization in the tables below, for 2015, LeBonheur East Surgery Center II, Methodist Surgery Center Germantown and the Surgery Center at Saint Francis all operated at above the standard of 884 cases per operating room, with the Surgery Center at Saint Francis operating at 150% of capacity.

Utilization of Operating and Procedure Rooms
Shelby County 2015

Multispecialty Ambulatory Surgical Treatment Centers						
	Operating Rooms (OR)	Cases Performed in all ORs	Cases per OR	Procedure Rooms (PR)	Cases Performed in all PRs	Cases per PR
Baptist Germantown Surgery Center	5	3,811	762	0	0	0
Campbell Clinic Surgery Center	4	3,483	871	1	3,769	3,769
Campbell Clinic Surgery Center Midtown	4	1,323	331	0	0	0
East Memphis Surgery Center	6	4,190	698	3	1,151	394
Le Bonheur East Surgery Center II	4	4,108	1,027	0	0	0
Memphis Surgery Center	4	2,652	663	1	0	0
Methodist Surgery Center Germantown	4	3,943	986	1	1,252	1,252
North Surgery Center	4	2,351	588	1	1,339	1,339
Semmes-Murphey Clinic	3	1,570	523	2	4,712	2,356
Surgery Center at Saint Francis	4	5,288	1,322	2	1,118	559
Single-specialty Ambulatory Surgical Treatment Centers						
	Operating Rooms (OR)	Cases Performed in all ORs	Cases per OR	Procedure Rooms (PR)	Cases Performed in all PRs	Cases per PR
Endoscopy Center of the Mid-South	0	0	0	1	2,022	2,022
Eye Care Surgery Center of Memphis	2	0	0	1	1,206	1,206
Germantown Ambulatory Surgical Center	1	106	106	0	0	0
GI Diagnostic and Therapeutic Center	0	0	0	6	15,128	2,521
Hamilton Eye Institute Surgery Center	3	3,527	1,176	2	545	273
Mays & Schnapp Pain Clinic & Rehabilitation Center	2	4,422	2,211	0	0	0
Memphis Center for Reproductive Health	0	0	0	2	2,124	1,062
Memphis Eye & Cataract Ambulatory Surgical Center	3	1,656	552	1	356	356
Memphis Gastroenterology Endoscopy Center	0	0	0	6	9,525	1,588
Mid-South Gastroenterology Group	0	0	0	3	7,506	2,502
Mid-South Interventional Pain Institute	0	0	0	2	2,728	1,364
Planned Parenthood Greater Memphis Region	0	0	0	2	3,311	1,656
Ridge Lake Ambulatory Surgery Center	2	4,493	2,247	4	2,448	612
Shea Clinic	2	2,263	1,132	0	0	0
Urocenter	3	3,648	1,216	0	0	0
Wesberry Surgery Center	1	1,500	1,500	0	0	0
Wolf River Surgery Center	4	2,749	687	2	2,480	1,240

Note: Minimum number of 884 cases per operating room and 1,867 per procedure room.
* No 2015 Joint Annual Report

Utilization of Operating and Procedure Rooms
Shelby County 2014

Multispecialty Ambulatory Surgical Treatment Centers						
	Operating Rooms (OR)	Cases Performed in all ORs	Cases per OR	Procedure Rooms (PR)	Cases Performed in all PRs	Cases per PR
Baptist Germantown Surgery Center	5	3,508	702	0	0	0
Campbell Clinic Surgery Center	4	3,089	772	1	4,264	4,264
Campbell Clinic Surgery Center Midtown	4	161	40	0	0	0
East Memphis Surgery Center	6	4,087	681	3	1,182	394
Le Bonheur East Surgery Center II	4	2,446	612	0	0	0
Memphis Surgery Center	4	2,730	683	1	131	131
Methodist Surgery Center Germantown	4	4,120	1,030	1	1,335	1,335
North Surgery Center	4	2,334	584	1	1,283	1,283
Semmes-Murphey Clinic	3	1,162	387	2	2,742	1,371
Surgery Center at Saint Francis	4	4,723	1,181	2	1,848	924
Single-specialty Ambulatory Surgical Treatment Centers						
	Operating Rooms (OR)	Cases Performed in all ORs	Cases per OR	Procedure Rooms (PR)	Cases Performed in all PRs	Cases per PR
Endoscopy Center of the Mid-South	0	0	0	1	2,226	2,226
Eye Care Surgery Center of Memphis	2	1,036	518	1	0	0
Germantown Ambulatory Surgical Center	1	113	113	0	0	0
GI Diagnostic and Therapeutic Center	0	0	0	6	16,230	2,705
Hamilton Eye Institute Surgery Center	3	3,334	1,111	2	474	237
Mays & Schnapp Pain Clinic & Rehabilitation Center	2	4,245	2,123	0	0	0
Memphis Eye & Cataract Ambulatory Surgical Center	4	2,097	524	0	0	0
Memphis Gastroenterology Endoscopy Center	0	0	0	6	9,613	1,602
Mid-South Gastroenterology Group	0	0	0	3	6,440	2,147
Mid-South Interventional Pain Institute	0	0	0	2	3,229	1,615
Radiosurgical Center	0	0	0	1	142	142
Ridge Lake Ambulatory Surgery Center	2	4,061	2,031	4	2,526	641
Shea Clinic	2	998	499	0	0	0
Urocenter	3	3,698	1,233	0	0	0
Wesberry Surgery Center	1	912	912	0	0	0
Wolf River Surgery Center	4	3,012	753	2	2,589	1,295

Note: Minimum number of 884 cases per operating room and 1,867 per procedure room.

Utilization of Operating and Procedure Rooms
Shelby County 2013

Multispecialty Ambulatory Surgical Treatment Centers						
	Operating Rooms (OR)	Cases Performed in all ORs	Cases per OR	Procedure Rooms (PR)	Cases Performed in all PRs	Cases per PR
Baptist Germantown Surgery Center	5	8,932	1,786	0	0	0
Campbell Clinic Surgery Center	4	3,274	819	1	3,954	3,954
Campbell Clinic Surgery Center Midtown	4	895	224	0	0	0
East Memphis Surgery Center	6	4,315	719	3	1,147	382
Le Bonheur East Surgery Center II	4	2,391	598	0	0	0
Memphis Surgery Center	4	2,913	728	1	136	136
Methodist Surgery Center Germantown	4	4,201	1,050	1	1,371	1,371
North Surgery Center	4	2,257	564	1	1,273	1,273
Semmes-Murphey Clinic	3	882	294	2	2,631	1,316
Surgery Center at Saint Francis	4	3,767	942	2	2,374	1,187
Single-specialty Ambulatory Surgical Treatment Centers						
	Operating Rooms	Cases Performed in all Operating Rooms	Cases per Room	Procedure Rooms	Cases Performed in all Procedure Rooms	Cases per Procedure Room
Endoscopy Center of the Mid-South	0	0	0	1	2,570	2,570
Eye Care Surgery Center of Memphis	2	1,088	544	1	0	0
Germantown Ambulatory Surgical Center	1	115	115	1	0	0
GI Diagnostic and Therapeutic Center	0	0	0	6	21,838	3,640
Hamilton Eye Institute Surgery Center	3	2,799	933	2	557	279
Mays & Schnapp Pain Clinic & Rehabilitation Center	2	4,215	2,108	0	0	0
Memphis Eye & Cataract Ambulatory Surgical Center	3	2,225	742	0	0	0
Memphis Gastroenterology Endoscopy Center	0	0	0	6	9,359	1,560
Mid-South Gastroenterology Group	0	0	0	3	6,597	2,199
Mid-South Interventional Pain Institute	0	0	0	2	3,549	1,775
Radiosurgical Center	0	0	0	1	154	154
Ridge Lake Ambulatory Surgery Center	2	3,102	1,551	4	1,513	378
Shea Clinic	2	3,498	1,749	0	0	0
Urocenter	3	3,357	3,357	0	0	0
Wesberry Surgery Center	1	912	912	0	0	0
Wolf River Surgery Center	4	2,815	704	2	2,704	1,352

Note: Minimum number of 884 cases per operating room and 1,867 per procedure room.

4. Need and Economic Efficiencies. An applicant must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are known and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above.

Response: The Surgery Center at Saint Francis, located at 5999 Park Avenue, in front of Saint Francis Hospital, is owned by Saint Francis Surgery Center, LLC. The utilization at this surgery center for operating room surgical cases is the highest in Shelby County in 2015 at 1,181 cases per operating room. The applicant anticipates that a significant number of its outpatient surgical volume will come from the cases currently being performed at the Surgery Center of Saint Francis, partly because of the type of case it is and partly because of the patients who are receiving services reside closer to the proposed Bartlett ASC site than the Surgery Center at Saint Francis. The shift of some of the surgical volume from the Surgery Center at Saint Francis will help the Surgery Center at Saint Francis to better manage its volume and not need to seek expansion, which would be very costly.

It is important to look at the market of multi-specialty surgery centers in Shelby County and note their ownership or affiliation. They are all either affiliated and/or owned by a hospital in the area, or limited to a particular physician group. Please see the table below.

Affiliations of ASTCs in Service Area

	Affiliations
Baptist Germantown Surgery Center	Baptist Memorial Hospital
Campbell Clinic Surgery Center	Campbell Clinic Orthopaedics
Campbell Clinic Surgery Center Midtown	Campbell Clinic Orthopaedics
East Memphis Surgery Center	Baptist Memorial Hospital
Le Bonheur East Surgery Center II	Methodist Healthcare
Memphis Surgery Center	Baptist Memorial Hospital
Methodist Surgery Center Germantown	Methodist Healthcare
North Surgery Center	Methodist Healthcare
Semmes-Murphey Clinic	Semmes-Murphey Clinic Physicians
Surgery Center at Saint Francis	Saint Francis Hospital

The applicant anticipates that the proposed surgery center will have the greatest impact on Saint Francis Hospital, Saint Francis Surgery Center, and Saint Francis Hospital-Bartlett. The applicant anticipates that the proposed ASTC should have little to no impact on other area ASTCs. As is shown in the table above, all of the multispecialty ASTCs in Shelby County are either affiliated with an existing hospital or limited to a particular physician group, as in the case of Campbell Clinic and Semmes-Murphey. As the applicant anticipates that the majority of its projected cases are expected to come from utilization of the Tabor Orthopedics Group, which performs more of its cases at Saint Francis Hospital, Saint Francis Surgery Center, and Saint Francis Hospital-Bartlett, than at any other surgery center, it should have

relatively little impact on the ASTCs that are affiliated with other hospital systems in Shelby County.

5. Need and Economic Efficiencies. An application for a Specialty ASTC should present its projections for the total number of cases based on its own calculations for the projected length of time per type of case, and shall provide any local, regional, or national data in support of its methodology. An applicant for a Specialty ASTC should provide its own definitions of the surgeries and/or procedures that will be performed and whether the Surgical Cases will be performed in an Operating Room or a Procedure Room. An applicant for a Specialty ASTC must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON proposal to establish a Specialty ASTC or to expand existing services of a Specialty ASTC shall not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above. An applicant that is granted a CON for a Specialty ASTC shall have the specialty or limitation placed on the CON.

Response: Not applicable. The ASTC is not applying for a Specialty ASTC. The applicant anticipates that orthopedic, pain management, and spinal procedures will be performed at the proposed ASTC upon its approval. It is possible the applicant will want to expand these service offerings based on demand in the service area.

Other Standards and Criteria

6. Access to ASTCs. The majority of the population in a Service Area should reside within 60 minutes average driving time to the facility.

Response: The majority of the population that is expected to receive services at this ASTC will be within 60 minutes driving time to the facility.

7. Access to ASTCs. An applicant should provide information regarding the relationship of an existing or proposed ASTC site to public transportation routes if that information is available.

Response: The proposed site is on Kate Bond Rd, one block off of Highway 64 in Bartlett, Tennessee. Memphis Area Transit Authority operates the Wolfchase bus route on Highway 64. The route provides regular daily service. This route connects with other bus service throughout the Memphis area. Due to patient discharge policies, however, bus and taxi access is not advisable. Patients generally arrive and leave via private automobile.

The location is very accessible by automobile. The proposed site is less than two miles off of Interstate 40. The location is between Highway 64 and Highway 79, both of which are major thoroughfares in Bartlett, providing easy access to the proposed site for the community.

8. Access to ASTCs. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center

must project the origin of potential patients by percentage and county of residence and, if such data are readily available, by zip code, and must note where they are currently being served. Demographics of the Service Area should be included, including the anticipated provision of services to out-of-state patients, as well as the identity of other service providers both in and out of state and the source of out-of-state data. Applicants shall document all other provider alternatives available in the Service Area. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

Response:

Bartlett ASC
Service Area by Zip Code

Area ZIP Code	City	Current Population
38134	Memphis	42,166
38002	Arlington	44,904
38135	Memphis	31,281
38016	Cordova	47,001
38133	Memphis	21,512
38128	Memphis	44,252
38053	Millington	28,522
38127	Memphis	44,267
38068	Somerville	10,631
38060	Oakland	10,015
38018	Cordova	37,082
38122	Memphis	25,362
38019	Covington	15,631
38004	Atoka	11,283
38058	Munford	10,649
38011	Brighton	9,522
38108	Memphis	18,452
38028	Eads	6,994
38023	Drummonds	5,416
38049	Mason	4,714
38111	Memphis	42,393
TOTAL		512,049

Demographic Characteristics of Service Area by County

Demographic	Shelby County	Fayette County	Tennessee
Median Age – 2010 US Census	34.6	43.1	38.0
Age 65+ Population – 2016	116,834	8,731	1,091,516
% of Total Population	12.2%	19.6%	16.0%
Age 65+ Population – 2020	135,234	11,171	1,266,295
% of Total Population	13.8%	23.0%	17.8%
Median Household Income	$46,213	$55,623	$44,621
TennCare Enrollees (4/16)	277,633	7,202	1,534,367
Percent of 2016 Population Enrolled in TennCare	28.9%	16.1%	22.5%
Persons Below Poverty Level (2016)	220,653	6,472	1,246,597
Persons Below Poverty Level as % of Population (US Census)	23.0%	14.5%	18.3%

9. Access and Economic Efficiencies. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following completion of the project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

Response:

Bartlett ASC
Projected Utilization for First Eight Quarters

	Year 1	Year 2
1st Quarter	171	804
2nd Quarter	394	804
3rd Quarter	631	804
4th Quarter	789	805
Total	1,985	3,217

10. Patient Safety and Quality of Care: Health Care Workforce.

a. An applicant should be or agree to become accredited by any accrediting organization approved by the Centers for Medicare and Medicaid Services, such as the Joint Commission, the Accreditation Association of Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgical Facilities, or other nationally recognized accrediting organization.

Response: The applicant will seek accreditation through The Joint Commission.

b. An applicant should estimate the number of physicians by specialty that are expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel. An applicant should provide documentation on the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

Response: The applicant anticipates initially credentialing approximately 15 orthopedic surgeons and two pain management physicians. Additionally, adequate anesthesiologists and CRNAs will be credentialed to manage and administer anesthesia services to the facilities' patients. Generally, an ASTC of this size would require the credentialing of approximately ten anesthesia providers that would practice at the center on a rotating basis. The facility plans to contract with pathologists to provide professional laboratory services to the center. Additionally, the facility plans to contract with a radiologist to provide oversight to the center's radiological safety program.

The applicant anticipates having sufficient staff for the ASTC with RNs, surgical technologists and office staff.

11. Access to ASTCs. In light of Rule 0720-11.01, which lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, "Every citizen should have reasonable access to health care," the HSDA may decide to give special consideration to an applicant:

a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;

Response: While the proposed service area does not qualify as a medically underserved area, there is currently no ASTC in this service area, with the exception of North Surgery Center, which is located on the campus of Methodist North Hospital.

b. Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program;

Response: Not applicable.

c. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program; or

Response: The applicant will be contracted with all TennCare MCOs and will participate in the Medicare program.

d. Who is proposing to use the ASTC for patients that typically require longer preparation and scanning times. The applicant shall provide in its application information supporting the additional time required per Case and the impact on the need standard.

Response: The applicant anticipates that the procedures to be performed in the procedure room will take on average 30 minutes.

STATE HEALTH PLAN

Tennessee Code Annotated Section 68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/finance/healthplanning/). The State Health Plan guides the state in the development of health care programs and policies and in the allocation of health care resources in the state, including the Certificate of Need program. The 5 Principles for Achieving Better Health form the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Please discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan. Each Principle is listed below with example questions to help the applicant in its thinking.

1. The purpose of the State Health Plan is to improve the health of Tennesseans.

   a. How will this proposal protect, promote, and improve the health of Tennesseans over time?

   Response: The addition of an ASTC in one of the fastest. growing areas of the state, when that is currently not an option for this area, will allow residents to receive necessary health care services in the least restrictive setting, making it easier and more convenient for residents which certainly promotes the health of those Tennesseans and may improve their health over time.

   b. What health outcomes will be impacted and how will the applicant measure improvement in health outcomes?

   Response: USPI participates in a full compliance and quality program. They measure hundreds of instances for each patient because they feel it is important to know that they are organized to provide the highest quality, their patients received care that restored or maintained their health; and they provided care in the most efficient manner so that patients returned to home, school or work as quickly as possible. When breakdowns occur, USPI has the information and infrastructure to improve.

c. How does the applicant intend to act upon available data to measure its contribution to improving health outcomes?

Response: Some of the metrics that USPI uses to evaluate quality include the following:

- % of cases, Surgical Safety Checklist Used
- % of Patients with a Perforation
- % of Patients that Received Antibiotics within One Hour
- % of Patients with Appropriate Hair Removal
- % Patients with VTE Risk Assessment
- % of Patients with VTE Prophylaxis
- Average Start Time - All
- Central Line Infection Numerator
- Death Within the Facility
- Falls
- Medication Variance
- Risk - Total Burns with Harm
- Surgical Site Infection
- Total Returns to Surgery for Removal of Foreign Body
- Wrong Site Incidents
- Non-Emergent Transfer before Treatment
- Non-Emergent Transfer after Treatment
- Emergent Transfer Prior to Treatment
- Emergent Transfer After Treatment
- All Transfers - ASC

2. Every citizen should have reasonable access to health care.

a. How will this proposal improve access to health care? You may want to consider geographic, insurance, use of technology, and disparity issues (including income disparity), among others.

Response: Allowing citizens the option of an ASTC will improve access to outpatient surgical services. In addition, this proposed ASTC plans to contract with all payers, including private, TennCare and Medicare.

b. How will this proposal improve information provided to patients and referring physicians?

Response: The entry into the market of a high quality, lower cost environment for outpatient surgical services will enable the referring physicians and the patients to have an additional alternative for outpatient surgical services.

c. How does the applicant work to improve health literacy among its patient population, including communications between patients and providers?

Response: The physicians carefully screen prospective patients to ensure that they are appropriate candidates for outpatient surgery at an ASTC. Prior to surgery, patients receive a pre-op phone call from the ASTC. After the patients have surgery, they are provided with discharge instructions. There is also a follow-up call post-op to ensure that the patient's surgical recovery is going well. The pre-op and post-op calls are made by a nurse of the ASTC and patients have the opportunity to ask questions and receive answers. USPI tracks these calls at other centers and has an 80-90% contact rate for these calls. At a minimum, every patient is left a message and asked to call the nurse back.

3. The State's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies, and the continued development of the State's health care system.

a. How will this proposal lower the cost of health care?

Response: The costs for outpatient surgical procedures in an ASTC are lower than those in a hospital. Currently many residents in the Bartlett area drive to the Surgery Center at Saint Francis, an ASTC alternative, that is not as convenient as the facility proposed, or receive surgery at Saint Francis Hospital or Saint Francis Hospital-Bartlett inpatient hospitals.

b. How will this proposal encourage economic efficiencies?

Response: Because the cost of outpatient surgeries performed in an ASTC are less than the alternative of those performed in a hospital, economic efficiencies will be achieved for those patients who make the decision to have surgery in the proposed facility.

c. What information will be made available to the community that will encourage a competitive market for health care services?

Response: Physician offices are generally in charge of scheduling the outpatient surgical services for their patients. They generally provide information to the patients as to their options for a facility to provide services. The approval of this ASTC will provide another option for patients and referring physicians.

4. Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers.

   a. How will this proposal help health care providers adhere to professional standards?

   Response: Some of the quality measures identified above, can be used to assist health care providers in providing services in accordance with the highest professional standards.

   b. How will this proposal encourage continued improvement in the quality of care provided by the health care workforce?

   Response: Because the applicant measures and keeps track of the quality of care provided at the ASTC as identified above, improvement in the quality of care provided by the health care workforce will be achieved.

5. The state should support the development, recruitment, and retention of a sufficient and quality health care workforce.*

   a. How will this proposal provide employment opportunities for the health care workforce?

   Response: The addition of a new ASTC will provide opportunities for employment for health care workers, including RNs, surgical technologists, and office staff.

   b. How will this proposal complement the existing Service Area workforce?

   Response: Candidates are readily available from within the existing healthcare industry and the applicant's affiliated facilities. The center will utilize a number of channels to secure needed staff, including posting in on-line recruiting platforms and engaging recruiting firms. The applicant's affiliated facilities in Memphis have a history of successfully recruiting professional and administrative staff because they provide competitive compensation and benefits and are committed to the retention of existing personnel.

NEED CONTINUED

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

   Response: This proposal is consistent both with the applicant facilities long-range development plan as well as for Tenet, which is the controlling owner for USPI, as well as the ultimate parent for Saint Francis Hospital-Bartlett.. As such it is also consistent with the long-range plans of the two Tenet hospitals in Shelby County - Saint Francis Hospital and Saint Francis Hospital - Bartlett. Hospitals have to be competitive and provide services better, faster and cheaper. One way this is being carried out is for minimally invasive procedures to be moved out of the hospital setting to an ASTC, which is a lower cost provider.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the

service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

Response: Please see map included as Attachment C, Need-3. Both a county map and a zip code map are included to identify the proposed service area.

4. A. Describe the demographics of the population to be served by this proposal.

Response: Please see the information included below:

Current and Projected Population Change In Service Area by County

Shelby County			
Age	**2016**	**2020**	**% Change**
0 to 17	247,503	252,312	1.9
18+	711,858	728,710	2.4
65+	116,834	135,234	15.7
Total	959,361	981,022	2.3
Tennessee			
Age	**2016**	**2020**	**% Change**
0 to 17	1,570,687	1,614,001	2.8
18+	5,241,318	5,494,030	4.8
65+	1,091,516	1,266,295	16.0
Total	6,812,005	7,108,031	4.3

Demographic Characteristics of Service Area by County

Demographic	Shelby County	Tennessee
Median Age – 2010 US Census	34.6	38.0
Age 65+ Population – 2016	116,834	1,091,516
% of Total Population	12.2%	16.0%
Age 65+ Population – 2020	135,234	1,266,295
% of Total Population	13.8%	17.8%
Median Household Income	$46,213	$44,621
TennCare Enrollees (3/16)	276,265	1,525,548
Percent of 2016 Population Enrolled in TennCare	28.8%	22.4%
Persons Below Poverty Level (2016)	220,653	1,246,597
Persons Below Poverty Level as % of Population (US Census)	23.0%	18.3%

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response: The Bartlett ASC, LLC anticipates being readily accessible to the service area population and will serve the elderly, women, racial and ethnic minorities, and low include groups.

Demographic Characteristics of Service Area by County

Demographic	Shelby County	Tennessee
Age 65+ Population – 2016	116,834	1,091,516
% of Total Population	12.2%	16.0%
Age 65+ Population – 2020	135,234	1,266,295
% of Total Population	13.8%	17.8%
TennCare Enrollees (3/16)	276,265	1,525,548
Percent of 2016 Population Enrolled in TennCare	28.8%	22.4%
Persons Below Poverty Level (2016)	220,653	1,246,597
Persons Below Poverty Level as % of Population (US Census)	23.0%	18.3%

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response: There are no ASTCs existing in Bartlett, nor are there any that have been approved but are unimplemented. Bartlett is the 12th largest city in the State of Tennessee and the 2nd largest city in Shelby County. According to the Memphis Chamber of Commerce, Bartlett is one of the fastest growing suburbs in Shelby County. Based on U.S. Census data, Bartlett's population grew by 6.7% between 2010 and 2014, whereas Shelby County as a whole grew by only 1.1% during the same period. The only ASTC in the entire service area is North Surgery Center, located on the campus of Methodist North Hospital.

Utilization of Operating and Procedure Rooms
Shelby County 2015

Multispecialty Ambulatory Surgical Treatment Centers						
	Operating Rooms (OR)	Cases Performed in all ORs	Cases per OR	Procedure Rooms (PR)	Cases Performed in all PRs	Cases per PR
Baptist Germantown Surgery Center	5	3,811	762	0	0	0
Campbell Clinic Surgery Center	4	3,483	871	1	3,769	3,769
Campbell Clinic Surgery Center Midtown	4	1,323	331	0	0	0
East Memphis Surgery Center	6	4,190	698	3	1,151	394
Le Bonheur East Surgery Center II	4	4,108	1,027	0	0	0
Memphis Surgery Center	4	2,652	663	1	0	0
Methodist Surgery Center Germantown	4	3,943	986	1	1,252	1,252
North Surgery Center	4	2,351	588	1	1,339	1,339
Semmes-Murphey Clinic	3	1,570	523	2	4,712	2,356
Surgery Center at Saint Francis	4	5,288	1,322	2	1,118	559
Single-specialty Ambulatory Surgical Treatment Centers						
	Operating Rooms (OR)	Cases Performed in all ORs	Cases per OR	Procedure Rooms (PR)	Cases Performed in all PRs	Cases per PR
Endoscopy Center of the Mid-South	0	0	0	1	2,022	2,022
Eye Care Surgery Center of Memphis	2	0	0	1	1,206	1,206
Germantown Ambulatory Surgical Center	1	106	106	0	0	0
GI Diagnostic and Therapeutic Center	0	0	0	6	15,128	2,521
Hamilton Eye Institute Surgery Center	3	3,527	1,176	2	545	273
Mays & Schnapp Pain Clinic & Rehabilitation Center	2	4,422	2,211	0	0	0
Memphis Center for Reproductive Health	0	0	0	2	2,124	1,062
Memphis Eye & Cataract Ambulatory Surgical Center	3	1,656	552	1	356	356
Memphis Gastroenterology Endoscopy Center	0	0	0	6	9,525	1,588
Mid-South Gastroenterology Group	0	0	0	3	7,506	2,502
Mid-South Interventional Pain Institute	0	0	0	2	2,728	1,364
Planned Parenthood Greater Memphis Region	0	0	0	2	3,311	1,656
Ridge Lake Ambulatory Surgery Center	2	4,493	2,247	4	2,448	612
Shea Clinic	2	2,263	1,132	0	0	0
Urocenter	3	3,648	1,216	0	0	0
Wesberry Surgery Center	1	1,500	1,500	0	0	0
Wolf River Surgery Center	4	2,749	687	2	2,480	1,240

Note: Minimum number of 884 cases per operating room and 1,867 per procedure room.

Utilization of Operating and Procedure Rooms
Shelby County 2014

Multispecialty Ambulatory Surgical Treatment Centers						
	Operating Rooms (OR)	Cases Performed in all ORs	Cases per OR	Procedure Rooms (PR)	Cases Performed in all PRs	Cases per PR
Baptist Germantown Surgery Center	5	3,508	702	0	0	0
Campbell Clinic Surgery Center	4	3,089	772	1	4,264	4,264
Campbell Clinic Surgery Center Midtown	4	161	40	0	0	0
East Memphis Surgery Center	6	4,087	681	3	1,182	394
Le Bonheur East Surgery Center II	4	2,446	612	0	0	0
Memphis Surgery Center	4	2,730	683	1	131	131
Methodist Surgery Center Germantown	4	4,120	1,030	1	1,335	1,335
North Surgery Center	4	2,334	584	1	1,283	1,283
Semmes-Murphey Clinic	3	1,162	387	2	2,742	1,371
Surgery Center at Saint Francis	4	4,723	1,181	2	1,848	924
Single-specialty Ambulatory Surgical Treatment Centers						
	Operating Rooms (OR)	Cases Performed in all ORs	Cases per OR	Procedure Rooms (PR)	Cases Performed in all PRs	Cases per PR
Endoscopy Center of the Mid-South	0	0	0	1	2,226	2,226
Eye Care Surgery Center of Memphis	2	1,036	518	1	0	0
Germantown Ambulatory Surgical Center	1	113	113	0	0	0
GI Diagnostic and Therapeutic Center	0	0	0	6	16,230	2,705
Hamilton Eye Institute Surgery Center	3	3,334	1,111	2	474	237
Mays & Schnapp Pain Clinic & Rehabilitation Center	2	4,245	2,123	0	0	0
Memphis Eye & Cataract Ambulatory Surgical Center	4	2,097	524	0	0	0
Memphis Gastroenterology Endoscopy Center	0	0	0	6	9,613	1,602
Mid-South Gastroenterology Group	0	0	0	3	6,440	2,147
Mid-South Interventional Pain Institute	0	0	0	2	3,229	1,615
Radiosurgical Center	0	0	0	1	142	142
Ridge Lake Ambulatory Surgery Center	2	4,061	2,031	4	2,526	641
Shea Clinic	2	998	499	0	0	0
Urocenter	3	3,698	1,233	0	0	0
Wesberry Surgery Center	1	912	912	0	0	0
Wolf River Surgery Center	4	3,012	753	2	2,589	1,295

Note: Minimum number of 884 cases per operating room and 1,867 per procedure room.

Utilization of Operating and Procedure Rooms
Shelby County 2013

Multispecialty Ambulatory Surgical Treatment Centers						
	Operating Rooms (OR)	Cases Performed in all ORs	Cases per OR	Procedure Rooms (PR)	Cases Performed in all PRs	Cases per PR
Baptist Germantown Surgery Center	5	8,932	1,786	0	0	0
Campbell Clinic Surgery Center	4	3,274	819	1	3,954	3,954
Campbell Clinic Surgery Center Midtown	4	895	224	0	0	0
East Memphis Surgery Center	6	4,315	719	3	1,147	382
Le Bonheur East Surgery Center II	4	2,391	598	0	0	0
Memphis Surgery Center	4	2,913	728	1	136	136
Methodist Surgery Center Germantown	4	4,201	1,050	1	1,371	1,371
North Surgery Center	4	2,257	564	1	1,273	1,273
Semmes-Murphey Clinic	3	882	294	2	2,631	1,316
Surgery Center at Saint Francis	4	3,767	942	2	2,374	1,187
Single-specialty Ambulatory Surgical Treatment Centers						
	Operating Rooms	Cases Performed in all Operating Rooms	Cases per Room	Procedure Rooms	Cases Performed in all Procedure Rooms	Cases per Procedure Room
Endoscopy Center of the Mid-South	0	0	0	1	2,570	2,570
Eye Care Surgery Center of Memphis	2	1,088	544	1	0	0
Germantown Ambulatory Surgical Center	1	115	115	1	0	0
GI Diagnostic and Therapeutic Center	0	0	0	6	21,838	3,640
Hamilton Eye Institute Surgery Center	3	2,799	933	2	557	279
Mays & Schnapp Pain Clinic & Rehabilitation Center	2	4,215	2,108	0	0	0
Memphis Eye & Cataract Ambulatory Surgical Center	3	2,225	742	0	0	0
Memphis Gastroenterology Endoscopy Center	0	0	0	6	9,359	1,560
Mid-South Gastroenterology Group	0	0	0	3	6,597	2,199
Mid-South Interventional Pain Institute	0	0	0	2	3,549	1,775
Radiosurgical Center	0	0	0	1	154	154
Ridge Lake Ambulatory Surgery Center	2	3,102	1,551	4	1,513	378
Shea Clinic	2	3,498	1,749	0	0	0
Urocenter	3	3,357	3,357	0	0	0
Wesberry Surgery Center	1	912	912	0	0	0
Wolf River Surgery Center	4	2,815	704	2	2,704	1,352

Note: Minimum number of 884 cases per operating room and 1,867 per procedure room.

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

Response: Please see the projected annual utilization for each of the two (2) years following completion of the project in the chart below.

Projected Annual Utilization

Specialty	Percentage of Cases	Year 1	Year 2
ACDF (Anterior Cervical Discectomy and Fusion)	2%	31	51
Lumbar	3%	63	102
UniCompartmental Knee Replacements	1%	13	20
Orthopedics	56%	1,122	1,820
Pain Management	38%	755	1,224
Total	100%	1,985	3,217

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

   - All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)

   - The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

   - The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

   - For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a contractor and/or architect that support the estimated construction costs.

     Response: Please see the project costs chart on the following page. The building will be developed and built by a developer and then leased to the applicant to use as a surgery center.

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees, Development Fee	$ 200,000.00
	3.	Acquisition of Site	
	4.	Preparation of Site	
	5.	Construction Costs	
	6.	Contingency Fund	
	7.	Fixed Equipment (Not included in Construction Contract)	
	8.	Moveable Equipment (List all equipment over $50,000)	$ 3,002,412.00
	9.	Other (Specify) Tenant Improvements	$ 2,901,353.00
	10.	Pre-Opening Expenses	$ 378,755.00
B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	$ 2,683,250.00
	2.	Building only	
	3.	Land only	
	4.	Equipment (Specify) _____	
	5.	Other (Specify) _____	
C.	Financing Costs and Fees:		
	1.	Interim Financing	
	2.	Underwriting Costs	
	3.	Reserve for One Year's Debt Service	
	4.	Other (Specify) Working Capital	$ 650,000.00
D.	Estimated Project Cost (A+B+C)		$ 9,815,770.00
E.	CON Filing Fee		$ 22,085.48
F.	Total Estimated Project Cost (D+E)	**TOTAL**	$ 9,837,855.48

2. Identify the funding sources for this project.

Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

☐ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

☐ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

☐ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

☐ D. Grants--Notification of intent form for grant application or notice of grant award; or

☐ E. Cash Reserves--Appropriate documentation from Chief Financial Officer.

☐ F. Other—Identify and document funding from all other sources.

Response: Not applicable. The applicant is not developing the project but anticipates leasing the building from a developer.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

Response: The square footage will be 13,500 square feet. The cost per square foot for the new construction is anticipated to be $217.50 per square foot. The cost per square foot for the recent Southern Hills Surgery Center CON application was $360. Below is a chart showing the statewide cost per square foot for ASTCs from 2012-2014. The cost per square foot for the proposed ASTC is similar to that of other approved facilities or CON applications.

Ambulatory Surgical Treatment Center Construction Cost Per Square Foot 2012-2014

	Renovated Construction	New Construction	Total Construction
First Quartile	$0 / sq ft	$0 / sq ft	$133.55 / sq ft
Median	$0 / sq ft	$0 / sq ft	$150.00 / sq ft
Third Quartile	$0 / sq ft	$0 / sq ft	$174.88 / sq ft

Source: HSDA Construction Cost Per Square Foot Charts, 2012-2014.
Note: Insufficient sample size to calculate renovated and new construction ranges

4. Complete Historical and Projected Data Charts on the following two pages--***Do not modify the Charts provided or submit Chart substitutions!*** Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available for the institution. Projected Data Chart requests information

for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

Response: Since this is a new project there is no historical information. Please see Projected Data Chart for the applicant.

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

Response: The applicant projects that the average gross charge for the first year of operation is $2,723.04, and $2,470.80 for the second year of operation. The revenue for outpatient services has already taken into consideration contractual adjustments and charity care. The only deduction that the applicant tracks separately is bad debt. The reason the gross charge is higher in the first year is because the applicant will not be credentialed with all payers on day one and there will be a ramp-up period, during which time the applicant will be considered out-of-network and will actually receive a higher reimbursement amount even though its volume is lower.

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in _____ (Month).
Response: Not applicable.

	Year____	Year___	*Year*_____
A. Utilization Data (Specify unit of measure)	_____	_____	_____
B. Revenue from Services to Patients			
1. Inpatient Services	$_____	$_____	$_____
2. Outpatient Services	_____	_____	_____
3. Emergency Services	_____	_____	_____
4. Other Operating Revenue (Specify)_____	_____	_____	_____
Gross Operating Revenue	**$_____**	**$_____**	**$_____**
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$_____	$_____	$_____
2. Provision for Charity Care	_____	_____	_____
3. Provisions for Bad Debt	_____	_____	_____
Total Deductions	**$_____**	**$_____**	**$_____**
NET OPERATING REVENUE	**$_____**	**$_____**	**$_____**
D. Operating Expenses			
1. Salaries and Wages	$_____	$_____	$_____
2. Physician's Salaries and Wages	_____	_____	_____
3. Supplies	_____	_____	_____
4. Taxes	_____	_____	_____
5. Depreciation	_____	_____	_____
6. Rent	_____	_____	_____
7. Interest, other than Capital	_____	_____	_____
8. Management Fees:			
a. Fees to Affiliates	_____	_____	_____
b. Fees to Non-Affiliates	_____	_____	_____
9. Other Expenses – Specify on separate page 12	_____	_____	_____
Total Operating Expenses	**$_____**	**$_____**	**$_____**
E. Other Revenue (Expenses) – Net (Specify)_____	$_____	$_____	$_____
NET OPERATING INCOME (LOSS)	**$_____**	**$_____**	**$_____**
F. Capital Expenditures			
1. Retirement of Principal	$_____	$_____	$_____
2. Interest	_____	_____	_____
Total Capital Expenditures	**$_____**	**$_____**	**$_____**
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	**$_____**	**$_____**	**$_____**

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 2017	Year 2018
A.	Utilization Data (Specify unit of measure)	1,985	3,217
B.	Revenue from Services to Patients		
1.	Inpatient Services	$ -	$ -
2.	Outpatient Services	5,572,401	8,194,383
3.	Emergency Services	-	-
4.	Other Operating Revenue (Specify) _____	-	-
	Gross Operating Revenue	$ 5,572,401	$ 8,194,383
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$ -	$ -
2.	Provision for Charity Care	-	-
3.	Provisions for Bad Debt	167,172	245,831
	Total Deductions	$ 167,172	$ 245,831
NET OPERATING REVENUE		$ 5,405,229	$ 7,948,552
D.	Operating Expenses		
1.	Salaries and Wages	$ 1,061,361	$ 1,352,415
2.	Physician's Salaries and Wages	-	-
3.	Supplies	1,395,618	2,330,441
4.	Taxes	164,469	164,469
5.	Depreciation	842,024	842,024
6.	Rent	387,964	387,964
7.	Interest, other than Capital		144,052
8.	Management Fees:		
	a. Fees to Affiliates	351,340	516,656
	b. Fees to Non-Affiliates	-	-
9.	Other Expenses – Specify on separate page 12	879,815	855,243
	Total Operating Expenses	$ 5,082,591	$ 6,459,212
E.	Other Revenue (Expenses) -- Net (Specify)_____	$ -	$ -
NET OPERATING INCOME (LOSS)		$ 322,638	$ 1,489,340
F.	Capital Expenditures		
1.	Retirement of Principal	$ 347,035	$ 366,611
2.	Interest	163,627	144,052
	Total Capital Expenditures	$ 510,662	$ 510,663
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$ (188,024)	$ 978,677

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___	*Year*____
1.	$	$	$
2.			
3.			
4.			
5.			
6.			
7.			
Total Other Expenses	**$**	**$**	**$**

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2017	Year 2018
1. Repairs and Maintenance	$ 186,000	$ 204,600
2. Purchased Services	200,000	206,000
3. Minor Equipment	50,000	51,250
4. Utilities	135,000	138,375
5. Non-Medical Supplies and Expenses	225,000	153,750
6. Professional Fees	50,000	51,250
7. Sales Expense	10,000	10,250
8. Insurance	23,815	39,768
Total Other Expenses	$ 879,815	$ 855,243

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response: The charge schedule for the most commonly anticipated procedures at the proposed ASTC is included as Attachment C, Economic Feasibility-6A. The applicant has projected revenue of $4.7M in its first year of operations. Since this is a new ASTC, there is no impact on existing patient charges. The rates for outpatient surgical procedures performed at an ASTC are generally lower than those performed in an acute care hospital.

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response: Please see Attachment C, Economic Feasibility-6B for a copy of the Medicare charge schedule for the most commonly anticipated procedures.

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

Response: The applicant anticipates having a positive net operating income in year 2.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response: The applicant anticipates having a slightly negative net operating income in year 1, which will be taken care of from cash reserves of the ultimate parent company, Tenet. The applicant anticipates having a positive net operating income in year 2.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response: The center will participate in the Medicare program. The center will participate in the TennCare program and expects to contract with the West Tennessee TennCare Managed Care Organizations: AmeriGroup, BlueCare, United Healthcare Community Plan, and TennCare Select. The applicant anticipates that 12% of the revenues, or $668,688.12, will be from Medicare and 1%, or $81,943.83, will be from TennCare.

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

Response: Since this is a new project, there is no existing balance sheet or income statement for the applicant. The majority owner of USPI is Tenet. Please see a copy of the financial information for Tenet included as Attachment C, Economic Feasibility-10.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

Response: There are no viable alternatives to the provision of these necessary health care services other than the proposed facility. All of the existing multi-specialty ASTCs in Shelby County are either affiliated and limited to a particular physician practice, or part of another hospital system. There are no existing ASTCs in Bartlett. The only ASTC in the service area is North Surgery Center, which is located on the campus of Methodist North. Bartlett is the 12th largest city in the State of Tennessee and the 2nd largest city in Shelby County. According to the Memphis Chamber of Commerce, Bartlett is one of the fastest growing suburbs in Shelby County. Based on U.S. Census data, Bartlett's population grew by 6.7% between 2010 and 2014, whereas Shelby County as a whole grew by only 1.1% during the same period.

The applicant is seeking to provide the services in the most cost effective manner, by leasing space that will be developed and built by a developer group. The developer is ValFund.

b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Response: There is no existing ASTC in the Bartlett service area other than North Surgery Center, which is on the campus of Methodist North Hospital and no suitable space that would suit the facility as well as the one proposed. The developer group is planning to build an MOB adjacent to the site for the ASTC. The proposed facility is less than a mile from Saint Francis Hospital-Bartlett.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

Response: The surgery center will be affiliated with St. Francis Hospital - Bartlett. The surgery center expects to contract with all predominate managed care insurers in the market including Blue Cross of Tennessee, United Healthcare, Cigna, and AETNA. The center will participate in the Medicare program and contract with Medicare Advantage Plans. The center will participate in the TennCare program and expects to contract with the West Tennessee TennCare Managed Care Organizations: AmeriGroup, BlueCare,

United Healthcare Community Plan, and TennCare Select. The applicant anticipates having transfer agreements with both Saint Francis Hospital and Saint Francis Hospital-Bartlett.

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

Response: There are only positive effects as a result of this proposal. The shift of outpatient procedures to a more convenient location will help alleviate the crowding at the Surgery Center of Saint Francis. The facilities whose utilization rates are expected to decrease are all Tenet facilities, so it is simply a shift of utilization between related entities. There is no duplication of services because there is currently no ASTC in the service area, with the exception of North Surgery Center, which is on the campus of Methodist North.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

Response: The center will operate with 18.0 FTEs, 14.0 of which are clinical positions. Candidates are readily available from within the existing healthcare industry and our affiliated facilities. The center will utilize a number of channels to secure needed staff, including posting in on-line recruiting platforms and engaging recruiting firms. Our affiliated facilities in Memphis have a history of successfully recruiting professional and administrative staff because they provide competitive compensation and benefits and are committed to the retention of existing personnel.

The following table summarizes proposed hourly wages for primary positions at the center compared to the area average.

Position	Projected Average Compensation at Center	Median in Memphis MSA
RN	$30.00	$28.32
Surgical Technologists	$25.00	$18.43
Office	$17.33	-

Source: Tennessee Department of Labor & Workforce Development website.

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response: Candidates are readily available from within the existing healthcare industry and our affiliated facilities. The center will utilize a number of channels to secure needed staff, including posting in on-line recruiting platforms and engaging recruiting firms. The applicant's affiliated facilities in Memphis have a history of successfully recruiting

professional and administrative staff because they provide competitive compensation and benefits and are committed to the retention of existing personnel.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education*.

Response: The applicant is familiar with all licensing requirements required by the State of Tennessee for medical/clinical staff.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.*, internships, residencies, etc.).

Response: The applicant does not plan to participate in the training of students; ASTCs do not generally participate in such training.

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

Response: The applicant has reviewed and understands the licensure requirements of the Department of Health as well as any applicable Medicare requirements.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure:

Response: The applicant will be licensed by the Tennessee Department of Health, Board for Licensing Health Care Facilities.

Accreditation:

Response: The applicant plans to seek accreditation from The Joint Commission.

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

Response: Not applicable.

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Response: Not applicable.

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

Response: Not applicable.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project

Response: Not applicable.

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

Response: The applicant will provide the Tennessee HSDA relevant information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Response: Please see attached confirming that publication occurred in *The Commercial Appeal on Tuesday, May 10, 2016.*

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

Response: The applicant anticipates completing the project within the required two year time period.

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in TCA § 68-11-1609(c): August 24, 2016

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase		DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1.	Architectural and engineering contract signed	___	___
2.	Construction documents approved by the Tennessee Department of Health	___	___
3.	Construction contract signed	___	___
4.	Building permit secured	___	___
5.	Site preparation completed	___	___
6.	Building construction commenced	___	___
7.	Construction 40% complete	___	___
8.	Construction 80% complete	___	___
9.	Construction 100% complete (approved for occupancy	___	___
10.	*Issuance of license	_____	_____
11.	*Initiation of service	_____	_____
12.	Final Architectural Certification of Payment	_____	_____
13.	Final Project Report Form (HF0055)	_____	_____

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

Attachment A-4

Organizational Documents
Organizational Chart

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

Bartlett ASC, LLC
STE 1600
15305 DALLAS PKWY
ADDISON, TX 75001-6491

May 2, 2016

Filing Acknowledgment

Please review the filing information below and notify our office immediately of any discrepancies.

SOS Control # :	**000846552**	Formation Locale:	TENNESSEE
Filing Type:	Limited Liability Company - Domestic	Date Formed:	05/02/2016
Filing Date:	05/02/2016 10:25 AM	Fiscal Year Close:	12
Status:	Active	Annual Report Due:	04/01/2017
Duration Term:	Perpetual	Image # :	B0230-4569
Managed By:	Director Managed		
Business County:	WILLIAMSON COUNTY		

Document Receipt

Receipt # : 002676482	Filing Fee:	$300.00
Payment-Check/MO - CFS-1, NASHVILLE, TN		$300.00

Registered Agent Address:
C T CORPORATION SYSTEM
STE 2021
800 S GAY ST
KNOXVILLE, TN 37929-9710

Principal Address:
STE 200
8 CADILLAC DR
BRENTWOOD, TN 37027-5316

Congratulations on the successful filing of your **Articles of Organization** for **Bartlett ASC, LLC** in the State of Tennessee which is effective on the date shown above. You must also file this document in the office of the Register of Deeds in the county where the entity has its principal office if such principal office is in Tennessee. Please visit the Tennessee Department of Revenue website (apps.tn.gov/bizreg) to determine your online tax registration requirements. If you need to obtain a Certificate of Existence for this entity, you can request, pay for, and recieve it from our website.

You must file an Annual Report with this office on or before the Annual Report Due Date noted above and maintain a Registered Office and Registered Agent. Failure to do so will subject the business to Administrative Dissolution/Revocation.

Tre Hargett
Secretary of State

Processed By: Jeff Cook

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY (ss-4270)

Business Services Division
Tre Hargett, Secretary of State
State of Tennessee
312 Rosa L. Parks AVE, 6th Fl.
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
(minimum fee = $300, maximum fee = $3,000)

For Office Use Only

FILED

The Articles of Organization presented herein are adopted in accordance with the provisions of the Tennessee Revised Limited Liability Company Act.

1. The name of the Limited Liability Company is: Bartlett ASC, LLC

(NOTE: Pursuant to the provisions of T.C.A. §48-249-106, each Limited Liability Company name must contain the words "Limited Liability Company" or the abbreviation "LLC" or "L.L.C.")

2. Name Consent: (Written Consent for Use of Indistinguishable Name)
☐ This entity name already exists in Tennessee and has received name consent from the existing entity.

3. This company has the additional designation of: _____

4. The name and complete address of the Limited Liability Company's initial registered agent and office located in the state of Tennessee is:
Name: CT Corporation System
Address: 800 S. Gay Street, Suite 2021
City: Knoxville State: TN Zip Code: 37929 County: Knox

5. Fiscal Year Close Month: 12/31

6. If the document is not to be effective upon filing by the Secretary of State, the delayed effective date and time is: (Not to exceed 90 days)
Effective Date: ____/____/____ (Month/Day/Year) Time: _____

7. The Limited Liability Company will be: ☐ Member Managed ☐ Manager Managed ☒ Director Managed

8. Number of Members at the date of filing: 1

9. Period of Duration: ☒ Perpetual ☐ Other ____/____/____ (Month/Day/Year)

10. The complete address of the Limited Liability Company's principal executive office is:
Address: 8 Cadillac Drive, Suite 200, Creekside Crossing III
City: Brentwood State: TN Zip Code: 37027 County: Williamson

ARTICLES OF ORGANIZATION
LIMITED LIABILITY COMPANY (ss-4270)

Business Services Division
Tre Hargett, Secretary of State
State of Tennessee
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Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
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For Office Use Only

The name of the Limited Liability Company is: Bartlett ASC, LLC

11. The complete mailing address of the entity (If different from the principal office) is:

Address: 15305 Dallas Parkway, Suite 1600

City: Addison State: Texas Zip Code: 75001

12. Non-Profit LLC (required only if the Additional Designation of "Non-Profit LLC" is entered in section 3.)

☐ I certify that this entity is a Non-Profit LLC whose sole member is a nonprofit corporation, foreign or domestic, incorporated under or subject to the provisions of the Tennessee Nonprofit Corporation Act and who is exempt from franchise and excise tax as not-for-profit as defined in T.C.A. §67-4-2004. The business is disregarded as an entity for federal income tax purposes.

13. Professional LLC (required only if the Additional Designation of "Professional LLC" is entered in section 3.)

☐ I certify that this PLLC has one or more qualified persons as members and no disqualified persons as members or holders.

Licensed Profession: _____

14. Series LLC (required only if the Additional Designation of "Series LLC" is entered in section 3.)

☐ I certify that this entity meets the requirements of T.C.A. §48-249-309(a) & (b)

15. Obligated Member Entity (list of obligated members and signatures must be attached)

☐ This entity will be registered as an Obligated Member Entity (OME) Effective Date: ____/____/____ (Month / Day / Year)

☐ I understand that by statute: THE EXECUTION AND FILING OF THIS DOCUMENT WILL CAUSE THE MEMBER(S) TO BE PERSONALLY LIABLE FOR THE DEBTS, OBLIGATIONS AND LIABILITIES OF THE LIMITED LIABILITY COMPANY TO THE SAME EXTENT AS A GENERAL PARTNER OF A GENERAL PARTNERSHIP. CONSULT AN ATTORNEY.

16. This entity is prohibited from doing business in Tennessee:

☐ This entity, while being formed under Tennessee law, is prohibited from engaging in business in Tennessee.

17. Other Provisions: _____

4/29/14
Signature Date

Wendy Beard
Signature

_____
Signer's Capacity (if other than individual capacity)

Wendy Beard
Name (printed or typed)

Rev. 10/12

RDA 2458

BK/PG:6735/895-898
16016674
4 PGS : LIMITED LIABILITY CO
JESSICA SWEENEY 432218 - 16016674
05/03/2016 - 10:15:21 AM

MORTGAGE TAX	0.00
TRANSFER TAX	0.00
RECORDING FEE	5.00
DP FEE	2.00
REGISTER'S FEE	0.00
TOTAL AMOUNT	7.00

STATE of TENNESSEE, WILLIAMSON COUNTY
SADIE WADE
REGISTER OF DEEDS

STATE OF TENNESSEE
Tre Hargett, Secretary of State
Division of Business Services
William R. Snodgrass Tower
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

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Tre Hargett
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Secretary of State

Processed By: Jeff Cook

Business Services Division
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312 Rosa L. Parks AVE, 6th Fl.
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Filing Fee: $50.00 per member
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Rev. 10/12

RDA 2468

TN043 - 2/15/2014 Wolters Kluwer Online

Business Services Division
Tre Hargett, Secretary of State
State of Tennessee
312 Rosa L. Parks AVE, 6th Fl.
Nashville, TN 37243-1102
(615) 741-2286

Filing Fee: $50.00 per member
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For Office Use Only

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Licensed Profession: _____

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17. Other Provisions: _____

4/29/14
Signature Date

Wendy Beard
Signature

Wendy Beard
Name (printed or typed)

Signer's Capacity (if other than individual capacity)

Rev. 10/12

RDA 2468

Affidavit

I, Lucretia Albert do hereby make oath that I am the custodian of the electronic version of the attached document tendered for registration herewith and that this is a true and correct copy of the original document executed and authenticated according to law.

Lucretia Albert
Signature

State of Tennessee

County of Davidson

Personally appeared before me, Ruth F. Arnold, a notary public for this county and state, Lucretia Albert, who acknowledges that this certification of an electronic document is true and correct and whose signature I have witnessed.

Ruth F. Arnold
Notary signature

My Commission Expires: August 20, 2019

Notary Seal:

E-recording Report of Recorded Documents

Itemized Fee View

Prepared for: Capital Filing Service, Inc.
For the period: 05/03/2016
Account number: TNT98D
Report generated: 05/03/2016 10:28 AM MDT

Documents Recorded

NAME	TYPE	PG	ENTRY	RECORD DATE		SF		AMT	TOTAL	PROCESSED
Williamson County, TN										
May 3, 2016										
Bartlett										
Bartlett ASC LLC	*LIMITED LIABILITY CO*	4	16016674 B 6735 P 0895	05/03/2016 10:15 AM CDT	Submission Fee	5.00	Recording Fee	7.00	12.00	05/03/2016
						0.00	No fee	0.00	0.00	05/03/2016
						5.00		***7.00***	***12.00***	
						5.00		**7.00**	**12.00**	
Totals for Williamson County, TN						**5.00**		**7.00**	**12.00**	

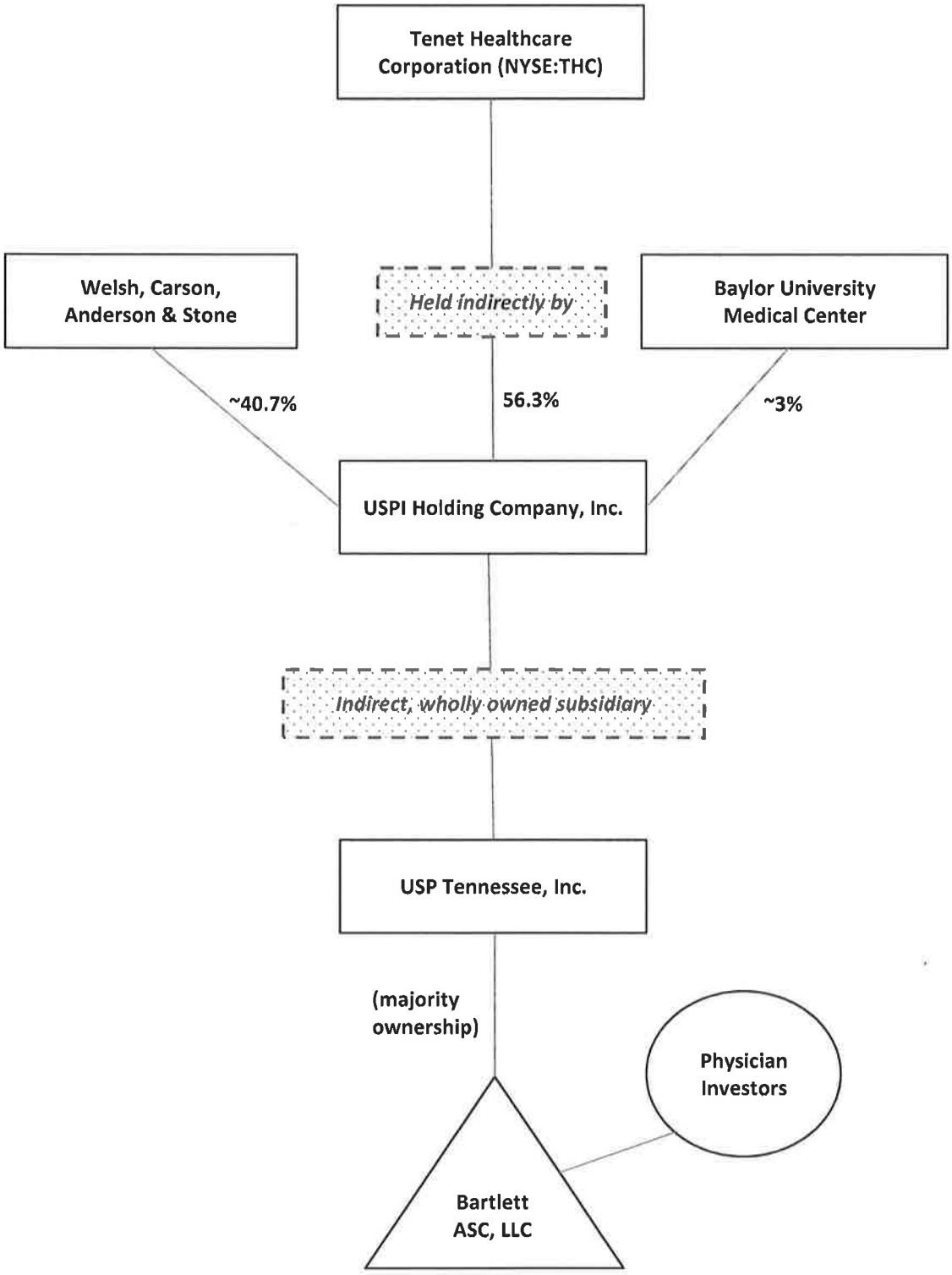
Recording Fee Totals

COUNTY	RECORD DATE	SF	AMT	
Williamson County, TN	05/03/2016	5.00	7.00	12.00
Totals for Williamson County, TN		**5.00**	**7.00**	**12.00**
Total of All Recording Fees		**5.00**	**7.00**	**12.00**

Document Count: 1

Included Organizations: Capital Filing Service, Inc.;

Questions Contact:
Simplifile Support 1-800-460-5657, option 3
4844 North 300 West, Suite 202
Provo, UT 84604


Tenet Healthcare Corporation (NYSE:THC)
Welsh, Carson, Anderson & Stone
Held indirectly by
Baylor University Medical Center
~40.7%
56.3%
~3%
USPI Holding Company, Inc.
Indirect, wholly owned subsidiary
USP Tennessee, Inc.
(majority ownership)
Physician Investors
Bartlett ASC, LLC

Attachment A-5

Draft Management Agreement

MANAGEMENT AGREEMENT
(_____ Surgery Center)

This Management Agreement ("Agreement") is made and entered into effective as of this ___ day of _____, 201_ ("Effective Date") by and between USP _____, Inc., a _____ corporation ("Manager"), and _____, [LLC] [L.P.], a _____ limited [liability company] [partnership] (the "Company"), with reference to the following facts:

RECITALS

A. Manager owns an interest in the Company.

B. The Company is [developing] [acquiring] and will operate [an ambulatory surgery center] [a surgical hospital] **[to be]** known as _____, located at _____, _____ (the "Surgery Center") **[, pursuant to a Contribution and Purchase Agreement, dated _____, 20___ (the "Purchase Agreement")]**.

C. In accordance with Section ___ of the **[Limited Partnership] [Operating]** Agreement of the Company, Manager and the Company desire to enter into an agreement whereby Manager will manage the Surgery Center for the Company.

NOW, THEREFORE, for good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, intending to be legally bound, the Company and Manager hereby agree as follows:

AGREEMENT

1. Management Services.

(a) The Company hereby engages Manager, and Manager hereby accepts the engagement, to provide day-to-day management services to and for the Surgery Center, subject to oversight and control by the Company as provided in Section 1(k) below. Such services shall include but are not limited to financial and operating system management, preparation of proposed annual budgets, purchasing, managed care relationships, expansion of the Surgery Center or its services, preparation of staffing plans, recruitment of personnel and medical staff and general supervision of the day-to-day operations of the Surgery Center. In addition, Manager shall consult with the Company regarding the development of an ongoing advertising and promotion program to be implemented by the Surgery Center at the Company's sole cost and expense, it being intended that Manager shall not directly or indirectly provide marketing for the Surgery Center or bring patients or induce referrals to the Surgery Center. In this regard, Manager and the Company will consider from time to time including the Surgery Center in the business development program of Manager's affiliate, United Surgical Partners International, Inc. ("Parent"). If the Surgery Center is included in this program, the Surgery Center will be responsible for the incremental cost associated with the program.

(b) In carrying out its duties, Manager shall have authority over charges, cash flow, planning, accounts receivable and third party payor reimbursements. Manager shall have the further authority and responsibility to manage all of the departments of the Surgery Center, establish charge schedules and promulgate personnel policies, including but not limited to qualifications and criteria for hiring and discharge of personnel; provided, however, that all medical and professional matters shall be the responsibility of the Company, the Medical Director and medical staff of the Surgery Center.

(c) Manager shall do or cause to be done all acts, procedures, authorizations and any and all other matters necessary, appropriate or related to obtaining and maintaining all necessary licenses, permits, provider numbers and approvals from all regulatory authorities having jurisdiction over the Surgery Center and/or its operations and accreditation by The Joint Commission, Accreditation Association for Ambulatory Health Care ("AAAHC") or other accrediting agencies designated by the Company.

(d) Manager shall maintain one or more local bank accounts for the Company in which it shall deposit the receipts from the business of the Surgery Center. Manager shall be entitled to make withdrawals from such account to pay authorized Surgery Center expenses, including payments to Manager in accordance with Section 3 hereof. The handling of receipts and disbursements with respect to such bank accounts shall be in accordance with customary business practices. Manager shall be entitled to invest such funds in connection with any cash management system employed by Parent (or its affiliate) on behalf of its affiliated surgery centers.

(e) Manager shall design, institute, supervise and from time to time revise and amend management, operational, financial and informational systems in order to conduct the physical and administrative operations of the Surgery Center, including but not limited to those required for billing and collection of charges, accounting and purchasing. Manager shall cause to be prepared and submitted in a proper manner and in a timely fashion any cost reports required to be submitted pursuant to the requirements of third party payors or any authority having jurisdiction over the Surgery Center.

(f) In accordance with applicable law, Manager shall negotiate and consummate agreements and contracts for and on behalf of the Surgery Center in the usual course of business, including without limitation managed care contracts (subject to pricing parameters established by the Company), radiology, laboratory and anesthesia contracts and contracts of insurance pursuant to the master insurance policies and programs maintained by Parent for its affiliated surgery centers. All such insurance policies shall name as insured parties the Company, Manager and such other persons as may be requested by the Company. Manager shall promptly notify the Company of all actual or threatened legal claims or actions affecting the Company and shall coordinate all legal matters and proceedings with counsel for the Company.

(g) Subject to the terms of the Operating Agreement, Manager, Parent or one of their affiliates shall locate, select and hire (or cause to be hired by or through an affiliate, which may include the Company), all Surgery Center personnel. All such personnel shall participate in and be

compensated through the employee benefit programs and payroll systems established from time to time by or for the benefit of Parent. All Surgery Center personnel shall be supervised by Manager as provided herein, regardless of the entity that is the employer.

(h) Manager will make available to the Surgery Center programs and assistance that are generally made available by Parent to its affiliated surgery centers, including cash management programs, business office management, legal assistance from Parent's in-house attorneys, Parent's EDGE [TM] quality monitoring and assurance program, patient grievance programs, performance measurement systems, practice improvement programs, compliance plans for government regulations (including Medicare and the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("HIPAA")) and other similar programs. The services above are generally included in the management fee payable to Manager pursuant to Section 3. Parent shall be entitled to charge the Company for incremental programs and systems on the same basis that it charges other affiliated surgery centers that are not wholly owned by Parent. These services may include the Kronos management clock, approved services contracted to third parties, group-purchased services such as liability insurance, IT hosting fees, some types of approved staff training, association dues and certain satisfaction surveys.

(i) Manager shall undertake all of its obligations and duties hereunder for the account of the Company and not for the account of Manager, and Manager shall have no responsibility or liability for performing any duties that involve making payments or incurring expenses unless the Company makes adequate funds available therefor. In carrying out its duties hereunder, Manager shall be an independent contractor and shall not be subject to any right of control, or any control in fact, of the Company over the methods by which it carries out its duties. Neither this Agreement nor the exercise of any of the duties of Manager hereunder shall be deemed to create any partnership, joint venture, association or other relationship between the parties hereto other than that of independent contractors each as to the other.

(j) Manager shall have the right to act as the agent of the Company and/or the Surgery Center in the procuring of licenses, permits and other approvals, the payment and collection of accounts and in all other activities necessary or useful to Manager in the carrying out of its duties as specified in this Agreement.

(k) Anything in this Section 1 to the contrary notwithstanding, Manager expressly acknowledges and agrees that the Company at all times during the term of this Agreement shall exercise the ultimate control and direction of the operations of the Surgery Center. Manager shall operate within any reasonable parameters, policies and procedures adopted by the Company and communicated to Manager by the Company, so long as such parameters, policies and procedures do not, in Manager's reasonable judgment, jeopardize the quality of patient care provided at the Surgery Center or require Manager or the Company to engage in any illegal or unethical acts.

2. **Term; Termination.**

(a) **Term of Agreement.** The term of this Agreement shall commence on the date first above written and, unless sooner terminated as provided in this Section 2, shall continue in effect so long as Manager or an affiliate of Manager or an assignee permitted by Section 10 continues to be an owner in the Company.

(b) **Termination Upon the Mutual Agreement of the Parties.** This Agreement may be terminated at any time upon the mutual agreement of Manager and the Company.

(c) **Termination for Default.** This Agreement may be terminated in the event of a Default (as defined in Section 8 hereof) by one party, subject to any applicable cure period, upon the nondefaulting party giving written notice of termination to the defaulting party.

3. **Management Fee.**

(a) As Manager's fee for its management services hereunder, Manager shall receive monthly an amount equal to **[seven]** percent of the net revenues of the Surgery Center during such month (or the portion thereof during which this Agreement is in effect). For purposes of this Section 3, "net revenues" shall be the Surgery Center's gross revenues from the delivery of medical and facility services at the Center (which does not include any physician professional fees), less adjustments for special contractual rates, charity work and an allowance for uncollectible accounts, all determined in accordance with generally accepted accounting principles. The fee for each month shall be paid on or before the 15th day of the succeeding month.

(b) In addition to the above fees, Manager shall be reimbursed by the Company for out-of-pocket expenses incurred on behalf of the Company, but shall not be reimbursed for any indirect or overhead expenses of Manager or its affiliates (except for incremental costs associated with Parent's business development program, if the Surgery Center is included in the program, as described in Section 1(a) hereof). Such reimbursement shall include, but is not limited to, all costs to Manager of providing the Surgery Center employees pursuant to Section 1(g) hereof (including without limitation all compensation and employee benefit costs) and reasonable travel expenses of corporate personnel of Parent and its affiliates who make periodic business trips to the Surgery Center.

(c) Except as otherwise provided in this Agreement, all of the costs and expenses of maintaining and operating the Surgery Center and its facilities shall be expenses of the Surgery Center, for the account of the Company, and shall not be expenses of Manager.

4. **Books and Records.**

(a) Manager shall supervise the maintenance of the books of account covering the operations of the Surgery Center. The general ledger may, if Manager so elects, be maintained by Manager through any centralized accounting system maintained by Parent. Such

books of account shall be maintained on an accrual basis in accordance with generally accepted accounting principles consistently applied.

(b) Manager shall prepare and furnish to the Company after the close of each fiscal quarter an unaudited financial statement reflecting the operations of the Company for such quarter. Manager shall cause to be prepared and furnished after the close of each fiscal year an unaudited balance sheet of the Company dated as of the end of the fiscal year and a related statement of income or loss for the Company for such fiscal year, all of which may (if the Company so elects) be certified in the customary manner by an independent certified public accountant approved by the Company. The expense of any such independent accountants shall be borne by the Company.

(c) Authorized agents of the Company shall have the right at all reasonable times during usual business hours to audit, examine and make copies of or extracts from the books of account of the Company maintained by Manager. Such right may be exercised through any agent, independent public accountant or employee of the Company designated by the Company. The Company shall bear all expenses incurred in any examination it makes pursuant hereto.

(d) If this Agreement is determined at any time during its term to be subject to the provisions of 42 Code of Federal Regulations, or any successor regulation which governs access to books and records of subcontractors of services to Medicare providers with a value or cost of $10,000 or more during a 12 month period, then Manager and its subcontractors shall make available, upon the request of the Secretary of Health and Human Services or the Comptroller General, the contracts, books, documents, and records necessary to verify the nature and extent of the cost of providing Medicare services under this Agreement, if any; provided, however, that any applicable attorney-client accountant-client or other legal privilege shall not be deemed waived by virtue of this Section 4(d). Such inspection shall be available up to four years after the rendering of such services.

5. **Representations of Manager.** Manager represents and warrants that it has been duly organized and is validly existing as a corporation in good standing under the laws of the State of _____, with full corporate power to own its properties and to conduct its business under such laws.

6. **Use of Name, Logos, etc.**. During the term of this Agreement, Manager shall have the right to utilize the name, trademarks, logos and symbols identifying the Surgery Center, including the right to represent to the public and the health care industry that the facilities and operations of the Surgery Center are managed by Manager. The Company shall not however, make any use of the name of Manager or Parent, or any of their trademarks, logos or symbols, without the prior written consent of Manager.

7. **Indemnification.** Manager does not hereby assume any of the obligations, liabilities or debts of the Company or the Surgery Center, except as otherwise expressly provided herein, and shall not, by virtue of its performance hereunder, assume or become liable for any of such obligations, debts or liabilities of the Company or the Surgery

Center. The Company hereby agrees to indemnify, defend and hold Manager harmless from and against any and all claims, actions, liabilities, losses, costs and expenses of any nature whatsoever, including reasonable attorneys' fees and other costs of investigating and defending any such claim or action, asserted against Manager on account of any of the obligations, liabilities or debts of the Company or the Surgery Center. The Company further agrees to defend, hold harmless and indemnify Manager and its officers, directors, employees and agents from and against any and all claims, actions, liabilities, losses, costs and expenses of any kind imposed on account of or arising out of actions taken in good faith by Manager or its officers, directors, employees or agents in what Manager or any such person reasonably believed to be within the scope of their responsibilities under this Agreement so long as such actions do not constitute gross negligence or intentional misconduct by the party requesting indemnification.

8. Default. The following events shall each constitute a "Default" under this Agreement: (a) the filing by either party hereto of a voluntary petition in bankruptcy or for reorganization under any bankruptcy law, or a petition for the appointment of a receiver for all or any substantial portion of the property of either party hereto, or any voluntary or involuntary steps to dissolve or suspend the corporate powers of either party unless such steps to dissolve or suspend are promptly removed; (b) the consent by either party hereto to an order for relief under the federal bankruptcy laws or the failure to vacate such an order for relief within 60 days from and after the date of entry thereof; (c) the entry of any order, judgment or decree, by any court of competent jurisdiction, on the application of a creditor, adjudicating either party hereto as a bankrupt, or to be insolvent, or approving a petition seeking reorganization or the appointment of a receiver, trustee or liquidator of all or a substantial part of such entity's assets, if such order, judgment or decree shall continue unstayed and in effect for any period of 60 days; and (d) any failure by either party to perform any of the material covenants, conditions or obligations of this Agreement in any material respect if such a failure shall continue for a period of 90 days after delivery to the defaulting party, by another party, of a written notice specifying such failure in sufficient detail, unless such failure is not susceptible of being cured within such 90 day period and the defaulting party commences such cure within such period and diligently prosecutes said cure to completion.

9. Competitive Services. It is hereby acknowledged that Manager, Parent and their affiliated companies are currently in the business of developing, owning and operating surgical hospitals, ambulatory surgery centers and other health facilities and providing ambulatory surgery center management services to the public apart from the services that Manager will provide to the Company under this Agreement. Nothing in this Agreement shall prohibit Manager or any of its affiliated companies from owning and operating surgical hospitals, ambulatory surgery centers or other health facilities or from providing such management services. This Section 9 shall not affect any noncompetition or other covenant to which Manager is subject pursuant to any other agreement to which Manager (or its affiliate) is a party.

10. Assignment. Except as specifically provided in this Section 10, Manager shall not have the right to assign its rights or delegate its duties hereunder to any unrelated organization unless it first obtains the written consent of the Company. Manager may assign this Agreement without consent to (a) Parent, (b) a majority owned subsidiary of Parent,

(c) a partnership, corporation or other entity that directly or indirectly owns a majority of the outstanding equity securities of Manager or (d) another partnership, corporation or entity that is, concurrently with such assignment, succeeding to all of Manager's interest in the Company or to substantially all of the assets and liabilities of Manager. All of the terms, provisions, covenants, conditions and obligations of this Agreement shall be binding on and inure to the benefit of the successors and assigns of the parties hereto.

11. Notices. Except as otherwise expressly permitted herein, all notices, demands or requests required or permitted to be given hereunder shall be in writing and shall be deemed to have been properly given or served when personally delivered or, if mailed, when deposited in the United States mail, postage prepaid, registered or certified, return receipt requested, or by facsimile transmission (with a confirmation by registered or certified mail placed in the mail no later than the following business day), or by sending the same by a nationally recognized overnight delivery service. Unless changed by written notice given by either party to the other party pursuant hereto, such notices shall be given to the parties at the following addresses:

If to the Company:

_____, [LLC] [L.P.]
_____
_____
_____
Attention: Administrator
Facsimile No.: (___)___-____

If to Manager:

_____
_____
_____
_____
Attention: Administrator
Facsimile No.: (___)___-____

All notices, demands or requests by personal delivery or by facsimile transmission shall be effective and deemed served upon transmittal thereof. All notices, demands and requests sent by mail shall be effective and deemed served three days after being deposited in the United States mail. All notices, demands and requests sent by overnight delivery service shall be effective and deemed served on the day after being deposited with such overnight delivery service.

12. Attorneys' Fees. If any action at law or in equity is brought to enforce any of the terms of this Agreement, the prevailing party shall be entitled to reasonable attorneys' fees and costs in addition to any other relief, as determined by the applicable court.

13. Entire Agreement. This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes any and all prior agreements, either oral or written, between the parties with respect thereto.

14. Enforceability. In the event that any of the provisions of this Agreement are held to be invalid or unenforceable by any court of competent jurisdiction, the remaining provisions hereof shall not be affected thereby.

15. Governing Law. This Agreement shall be governed by and construed in accordance with _____ law, without regard to its conflicts of law principles.

16. Counterparts; Execution. This Agreement may be executed in multiple counterparts which, when taken together, shall constitute one instrument. Signatures transmitted by facsimile or via other electronic transmission system shall be accepted as original signatures.

17. HIPAA Compliance. The parties agree that, in order to comply with HIPAA, Manager and its affiliates shall meet all requirements and obligations contained in the Business Associate Exhibit attached hereto and incorporated herein by this reference.

18. Amendments; Waiver. This Agreement may be amended, modified, superseded or canceled, and any of the terms, provisions, covenants, representations, warranties or conditions hereof may be waived, only by a written instrument executed by the Company and Manager or, in the case of a waiver, by the party waiving compliance.

[Signatures on next page]

IN WITNESS WHEREOF, the parties hereto have executed this Management Agreement as of the day and year first above written.

USP _____, INC.

By _____
Name _____
Title _____

_____, **[LLC] [L.P.]**

By _____
Name _____
Title _____

Attachment A-6

Draft Option to Lease

OPTION TO LEASE AGREEMENT

THIS OPTION TO LEASE AGREEMENT (the "Agreement") is made and entered into as of this _____ day of May 2016, by and between _____, a _____ _____ ("Landlord") and Bartlett ASC, LLC, a Tennessee limited liability company ("Tenant").

WITNESSETH

WHEREAS, Landlord has plans to construct a building located at 0 Kate Bond Boulevard, Bartlett (address to be assigned) in Shelby County, Tennessee (the "Property"); and

WHEREAS, Landlord desires to enter into an option with Tenant whereby Landlord grants to Tenant the option to lease approximately 13,500 square feet of the Property (the "Leased Premises"), which option must be exercised as set forth below.

NOW, THEREFORE, for and in consideration of the mutual promises set forth herein and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

SECTION 1
GRANT OF OPTION

1.1 Landlord hereby grants to Tenant an exclusive option to lease the Leased Premises, upon the terms and conditions set forth herein.

1.2 The term of Tenant's option to lease the Leased Premises shall commence on the date hereof and shall continue for a period of [___ (__)] months from the date hereof (the "Option Period"). The Option Period may be extended at any time prior to its expiration upon the mutual consent of the parties.

1.3 Tenant shall exercise its option to lease the Leased Premises by delivering written notice to Landlord within the Option Period by Registered or Certified Mail, or in person.

1.4 The parties agree hereto that this option to lease is contingent upon the Tenant obtaining a Certificate of Need to establish an ambulatory surgical treatment center from the State of Tennessee Health Services and Development Agency which is not subject to a contested case hearing.

SECTION 2
TERMS AND CONDITIONS OF THE LEASE

2.1 The parties agree to execute a formal lease agreement, subject to any terms and conditions contained in this Agreement and as mutually agreed upon by the parties. The parties expect that rent shall reflect the fair market value of the property and shall be $30.00 per square foot.

2.2 The term of Tenant's lease of the Leased Premises shall be for a period of [___ (__)] years (the "Term").

SECTION 3
MISCELLANEOUS PROVISIONS

3.1 Any notices required or permitted herein shall be addressed as follows and delivered to the other party by either registered or certified mail, facsimile, or in person:

If to Landlord:

_____
_____
_____

If to Tenant:

Bartlett ASC, LLC
c/o USP Tennessee, Inc.
15305 Dallas Parkway
Suite 1600
Addison, TX 75001
Attention: Chief Legal Officer

With a copy to:

United Surgical Partners International, Inc.
15305 Dallas Parkway
Suite 1600
Addison, TX 75001
Attn: James Bowden, Senior Corporate Counsel, Development

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by such party, as of the date first above written.

LANDLORD:
[_____]

By:_____
Title:_____

TENANT:
Bartlett ASC, LLC

By:_____
Title:_____

Attachment B, Project Description-I

Executive Summary

USPI Surgery Centers

Baptist Ambulatory Surgery Center
312 21st Avenue North
Suite 200, Creekside Crossing 111
Nashville, TN 37236-0000
Phone: (615) 321-7330
Fax: (615) 320-5319

Baptist Plaza Surgicare
2011 Church Street, Plaza I, Lower Level
Lower Level Dock E, 21st Avenue
Nashville,TN 37236
Phone: (615) 515-4000
Fax: (615) 515-4053

Chattanooga Pain Center
1016 Executive Drive
Hixson, TN 37343
Phone: (423) 648-4525
Fax: (423) 648-4626

Clarksville Surgery Center
793 Weatherly Drive
Clarksville, TN 37043
Phone: (931) 542-2915
Fax: (931) 648-1816

Eye Surgery Center of Nashville
310 25th Avenue N. Suite 105
Nashville, TN 37203
Phone: (615) 329-9023
Fax: (615) 329-1665

Franklin Endoscopy Center
740 Cool Springs Blvd
Ste. 210B
Franklin, TN 37067-6450
Phone: (615) 550-6066
Fax: (615) 550-6069

Lebanon Endoscopy Center
100 Physicians Way, Suite 340
Lebanon, TN 37090
Phone: (615) 466-9532
Fax: (615) 466-9536

Middle Tennessee Ambulatory Surgery Center
1800 Medical Center Parkway
Suite 120
Murfreesboro, TN 37129
Phone: (615) 849-7500
Fax: (615) 907-4020

Mid-State Endoscopy Center
1115 Dow Street, Suite A
Murfreesboro, TN 37130-2443
Phone: (615) 848-9234
Fax: (615) 893-3188

Mountain Empire Surgery Center
601 Med Tech Parkway
Suite 270
Johnson City, TN 37604
Phone: (423) 610-1020
Fax: (423) 610-1021

Nashville EndoSurgery Center
300 20th Avenue North
Nashville, TN 37203
Phone: (615) 284-1335
Fax: (615) 284-1316

Northridge Surgery Center
647 Myatt Drive
Madison, TN 37115
Phone: (615) 868-8942
Fax: (615) 860-3820

Parkwest Surgery Center
9430 Parkwest Boulevard
Suite 210
Knoxville, TN 37923
Phone: (865) 531-0494
Fax: (865) 531-0554

Patient Partners Surgery Center
890 North Blue Jay Way
Gallatin, TN 37066
Phone: (615) 575-9000
Fax: (615) 575-9007

Physicians Pavilion Surgery Center
545 Stonecrest Parkway
Smyrna, TN 37167
Phone: (615) 220-3720
Fax: (615) 459-9483

Physician's Surgery Center of Chattanooga
924 Spring Creek Road
Chattanooga, TN 37412
Phone: (423) 899-1600
Fax: (423) 899-2171

Physician's Surgery Center of Knoxville
1819 Clinch Avenue
Suite 206
Knoxville, TN 37916-2435
Phone: (865) 522-2949
Fax: (865) 637-3259

Providence Surgery Center
5002 Crossing Circle,Suite 110
Mt. Juliet, TN 37122
Phone: (615) 553-9100
Fax: (615) 553-9109

Saint Francis Surgery Center
5999 Park Avenue
Memphis, TN 38119

Saint Thomas Surgicare
4230 Harding Pike Road
Medical Plaza East
Suite 300
Nashville, TN 37205
Phone: (615) 783-1260
Fax: (615) 783-1261

The Hospital for Spinal Surgery
2011 Murphy Ave
Suite 200, Creekside Crosing 111
Nashville, TN 37203
Phone: (615) 341-7500
Fax: (615) 341-7513

Tullahoma Surgery Center
725 Kings Lane
Tullahoma, TN 37388
Phone: (931) 455-1976
Fax: (931) 455-7122

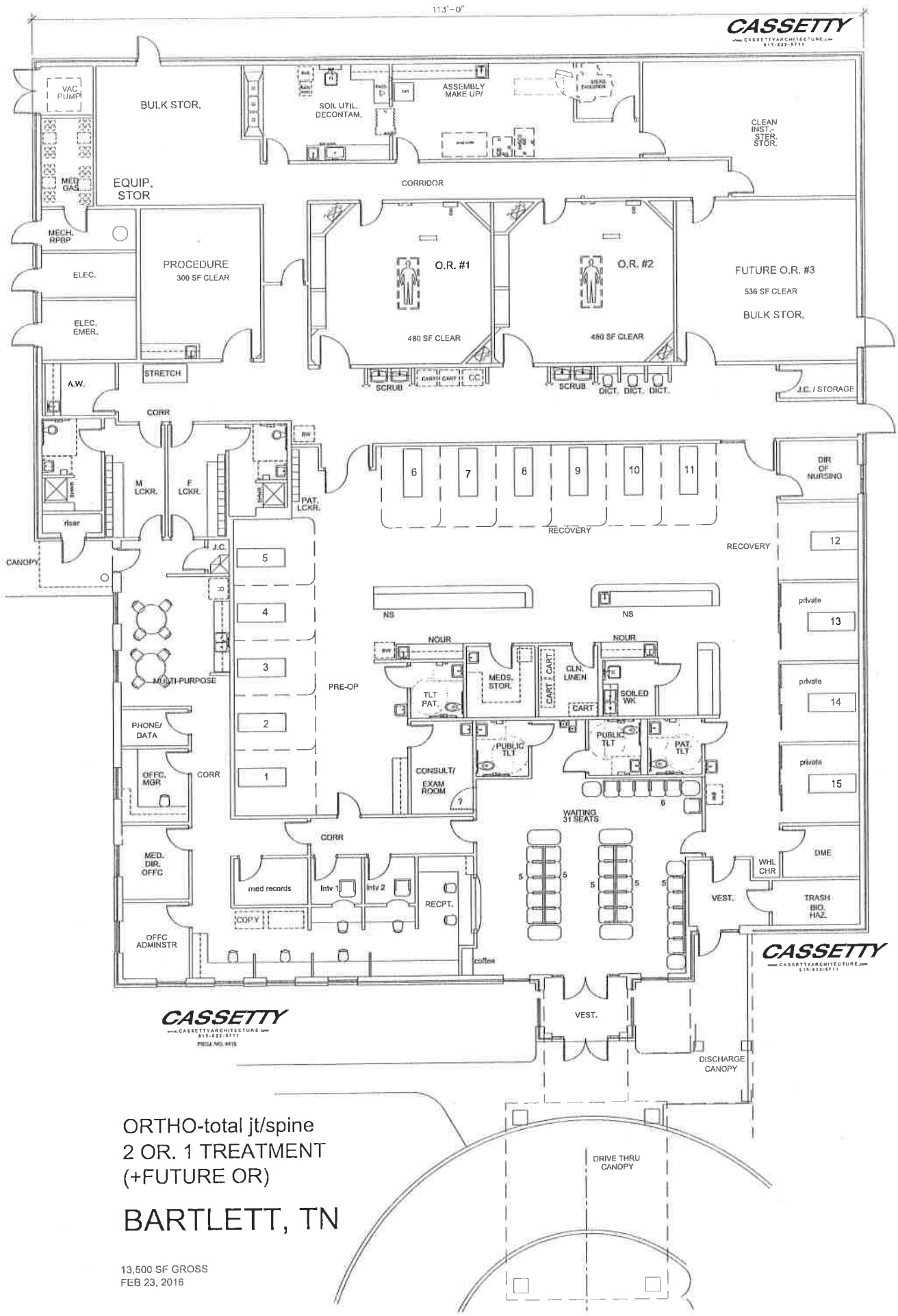
Upper Cumberland Physician Surgery Center
467 North Whitney Avenue
Cookeville, TN 38501
Phone: (931) 528-5007
Fax: (931) 528-5030

Attachment B, Project Description, III.A-4

Plot Plan

Attachment B, Project Description, IV

Floor Plan



ORTHO-total jt/spine
2 OR. 1 TREATMENT
(+FUTURE OR)

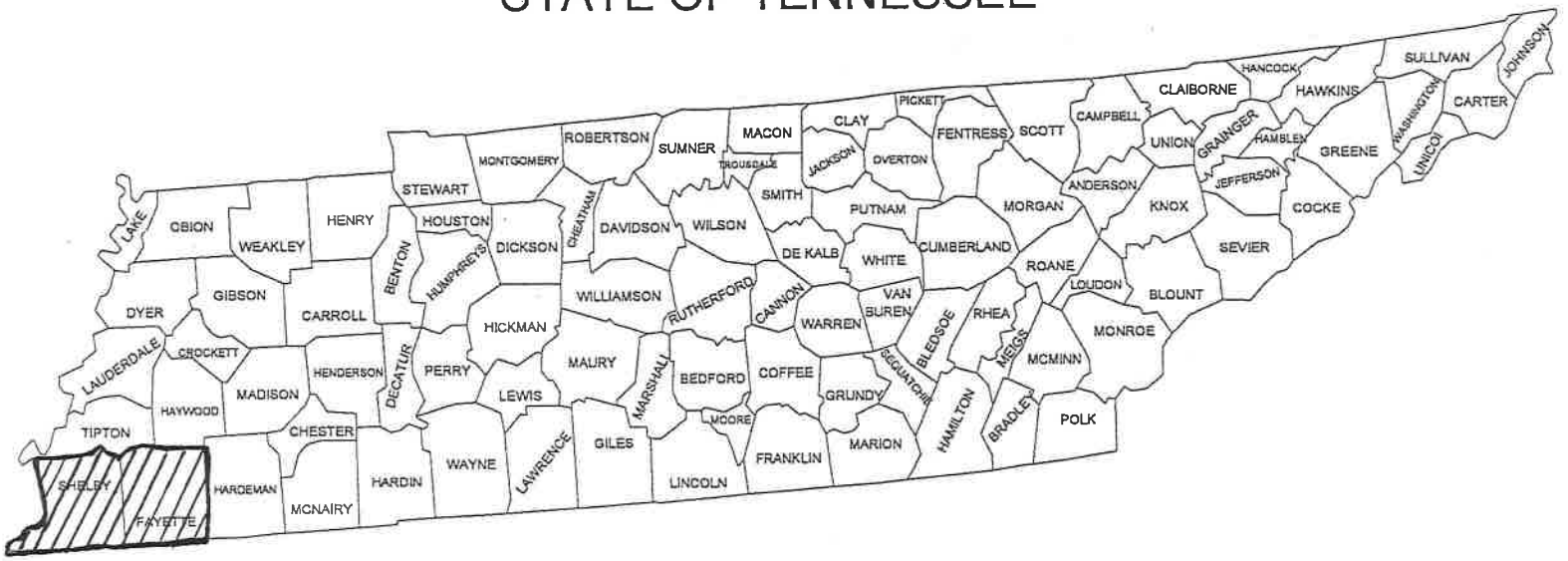
BARTLETT, TN

13,500 SF GROSS
FEB 23, 2016

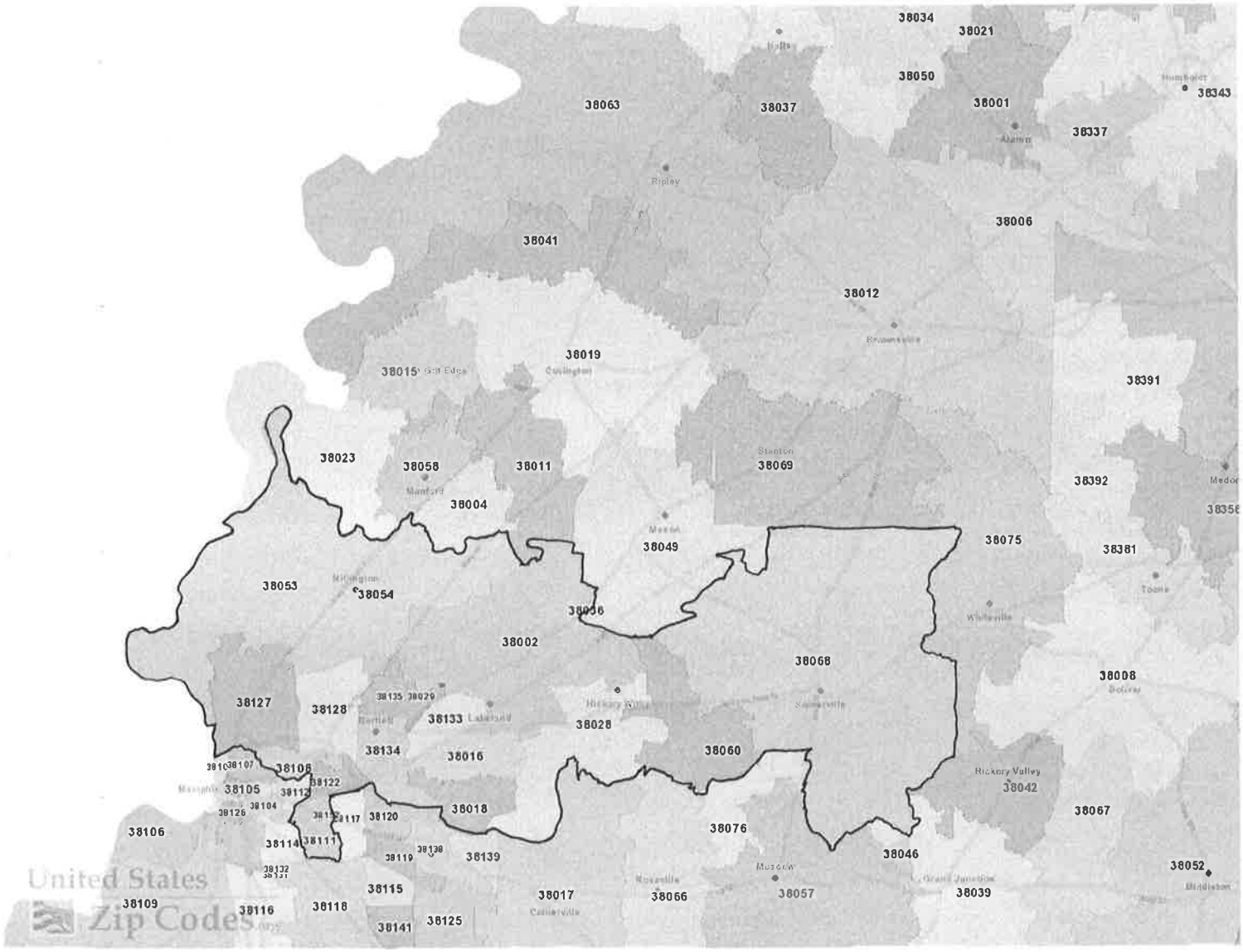
Attachment C, Need 3

Map of Service Area by County
Map of Service Area by Zip Code

STATE OF TENNESSEE



PROPOSED SERVICE AREA



Attachment C, Economic Feasibility – 6A

Fee Schedule

Most Common Procedures with Fees

CPT Code	Description	Std Fee	Fee
29826	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION OF SUBACROMIAL SPACE WITH PARTIAL ACROMIOPLASTY, WITH OR WITHOUT CORACOACROMIAL RELEASE	7,031.00	7,031.00
29824	ARTHROSCOPY, SHOULDER, SURGICAL; DISTAL CLAVICULECTOMY INCLUDING DISTAL ARTICULAR SURFACE (MUMFORD PROCEDURE)	7,031.00	7,031.00
29881	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCECTOMY (MEDIAL OR LATERAL, INCLUDING ANY MENISCAL SHAVING)	4,784.00	4,784.00
29827	ARTHROSCOPY, SHOULDER, SURGICAL; WITH ROTATOR CUFF REPAIR	7,031.00	7,031.00
62311	INJECTION, SINGLE (NOT VIA INDWELLING CATHETER), NOT INCLUDING NEUROLYTIC SUBSTANCES, WITH OR WITHOUT CONTRAST (FOR EITHER LOCALIZATION OR EPIDUROGRAPHY), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTH	2,008.00	2,008.00
64493	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SINGLE LEVEL	2,008.00	2,008.00
29888	ARTHROSCOPICALLY AIDED ANTERIOR CRUCIATE LIGAMENT REPAIR/AUGMENTATION OR RECONSTRUCTION	9,835.75	9,835.75
29880	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCECTOMY (MEDIAL AND LATERAL, INCLUDING ANY MENISCAL SHAVING)	4,784.00	4,784.00
29806	ARTHROSCOPY, SHOULDER, SURGICAL; CAPSULORRHAPHY	7,031.00	7,031.00
64494	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	2,008.00	2,008.00
64483	INJECTION, ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL; LUMBAR OR SACRAL, SINGLE LEVEL	2,008.00	2,008.00
64721	NEUROPLASTY AND/OR TRANSPOSITION; MEDIAN NERVE AT CARPAL TUNNEL	2,767.00	2,767.00
29877	ARTHROSCOPY, KNEE, SURGICAL; DEBRIDEMENT/SHAVING OF ARTICULAR CARTILAGE (CHONDROPLASTY)	4,784.00	4,784.00
28270	CAPSULOTOMY; METATARSOPHALANGEAL JOINT, WITH OR WITHOUT TENORRHAPHY, EACH JOINT (SEPARATE PROCEDURE)	3,152.00	3,152.00
64415	INJECTION, ANESTHETIC AGENT; BRACHIAL PLEXUS, SINGLE	1,384.00	1,384.00
64636	DESTRUCTION BY NEUROLYTIC AGENT, PARAVETEBRAL FACET JOINT NERVE(S) WITH IMAGING GUIDANCE LUMBAR OR SACRAL, EACH ADDL FACET JOINT	2,008.00	2,008.00
29828	ARTHROSCOPY, SHOULDER, SURGICAL; BICEPS TENODESIS	7,031.00	7,031.00
29898	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS), SURGICAL; DEBRIDEMENT, EXTENSIVE	4,784.00	4,784.00
62310	INJECTION, SINGLE (NOT VIA INDWELLING CATHETER), NOT INCLUDING NEUROLYTIC SUBSTANCES, WITH OR WITHOUT CONTRAST (FOR EITHER LOCALIZATION OR EPIDUROGRAPHY), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTH	2,008.00	2,008.00

27691	TRANSFER OR TRANSPLANT OF SINGLE TENDON (WITH MUSCLE REDIRECTION OR REROUTING); DEEP (EG, ANTERIOR TIBIAL OR POSTERIOR TIBIAL THROUGH INTEROSSEOUS SPACE, FLEXOR DIGITORUM LONGUS, FLEXOR HALLUCIS LONGUS, OR PERONEAL TENDON TO MIDFOOT OR HINDFOOT)	6,438.00	6,438.00
64635	DESTRUCTION BY NEUROLYTIC AGENT, PARAVETEBRAL FACET JOINT NERVE(S) WITH IMAGING GUIDANCE LUMBAR OR SACRAL, SINGLE FACET JOINT	2,008.00	2,008.00
64495	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE F	2,008.00	2,008.00
28308	OSTEOTOMY, WITH OR WITHOUT LENGTHENING, SHORTENING OR ANGULAR CORRECTION, METATARSAL; OTHER THAN FIRST METATARSAL, EACH	3,900.00	3,900.00

Attachment C, Economic Feasibility – 6B

Medicare Fee Schedule

Most Common Procedures with Fees

CPT Code	Description	Standard Fee	Medicare Allowable*
29826	ARTHROSCOPY, SHOULDER, SURGICAL; DECOMPRESSION OF SUBACROMIAL SPACE WITH PARTIAL ACROMIOPLASTY, WITH OR WITHOUT CORACOACROMIAL RELEASE	7,031.00	N1
29824	ARTHROSCOPY, SHOULDER, SURGICAL; DISTAL CLAVICULECTOMY INCLUDING DISTAL ARTICULAR SURFACE (MUMFORD PROCEDURE)	7,031.00	$ 1,260.00
29881	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCECTOMY (MEDIAL OR LATERAL, INCLUDING ANY MENISCAL SHAVING)	4,784.00	$ 1,260.00
29827	ARTHROSCOPY, SHOULDER, SURGICAL; WITH ROTATOR CUFF REPAIR	7,031.00	$ 2,339.00
62311	INJECTION, SINGLE (NOT VIA INDWELLING CATHETER), NOT INCLUDING NEUROLYTIC SUBSTANCES, WITH OR WITHOUT CONTRAST (FOR EITHER LOCALIZATION OR EPIDUROGRAPHY), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTH	2,008.00	$ 308.00
64493	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SINGLE LEVEL	2,008.00	$ 432.00
29888	ARTHROSCOPICALLY AIDED ANTERIOR CRUCIATE LIGAMENT REPAIR/AUGMENTATION OR RECONSTRUCTION	9,835.75	$ 3,323.00
29880	ARTHROSCOPY, KNEE, SURGICAL; WITH MENISCECTOMY (MEDIAL AND LATERAL, INCLUDING ANY MENISCAL SHAVING)	4,784.00	$ 1,260.00
29806	ARTHROSCOPY, SHOULDER, SURGICAL; CAPSULORRHAPHY	7,031.00	$ 2,339.00
64494	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	2,008.00	N1
64483	INJECTION, ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL; LUMBAR OR SACRAL, SINGLE LEVEL	2,008.00	$ 308.00
64721	NEUROPLASTY AND/OR TRANSPOSITION; MEDIAN NERVE AT CARPAL TUNNEL	2,767.00	$ 733.00
29877	ARTHROSCOPY, KNEE, SURGICAL; DEBRIDEMENT/SHAVING OF ARTICULAR CARTILAGE (CHONDROPLASTY)	4,784.00	$ 1,260.00
28270	CAPSULOTOMY; METATARSOPHALANGEAL JOINT, WITH OR WITHOUT TENORRHAPHY, EACH JOINT (SEPARATE PROCEDURE)	3,152.00	$ 766.00
64415	INJECTION, ANESTHETIC AGENT; BRACHIAL PLEXUS, SINGLE	1,384.00	$ 432.00
64636	DESTRUCTION BY NEUROLYTIC AGENT, PARAVETEBRAL FACET JOINT NERVE(S) WITH IMAGING GUIDANCE LUMBAR OR SACRAL, EACH ADDL FACET JOINT	2,008.00	N1
29828	ARTHROSCOPY, SHOULDER, SURGICAL; BICEPS TENODESIS	7,031.00	$ 2,339.00

29898	ARTHROSCOPY, ANKLE (TIBIOTALAR AND FIBULOTALAR JOINTS), SURGICAL; DEBRIDEMENT, EXTENSIVE	4,784.00	$ 1,260.00
62310	INJECTION, SINGLE (NOT VIA INDWELLING CATHETER), NOT INCLUDING NEUROLYTIC SUBSTANCES, WITH OR WITHOUT CONTRAST (FOR EITHER LOCALIZATION OR EPIDUROGRAPHY), OF DIAGNOSTIC OR THERAPEUTIC SUBSTANCE(S) (INCLUDING ANESTHETIC, ANTISPASMODIC, OPIOID, STEROID, OTH	2,008.00	$ 308.00
27691	TRANSFER OR TRANSPLANT OF SINGLE TENDON (WITH MUSCLE REDIRECTION OR REROUTING); DEEP (EG, ANTERIOR TIBIAL OR POSTERIOR TIBIAL THROUGH INTEROSSEOUS SPACE, FLEXOR DIGITORUM LONGUS, FLEXOR HALLUCIS LONGUS, OR PERONEAL TENDON TO MIDFOOT OR HINDFOOT)	6,438.00	$ 1,260.00
64635	DESTRUCTION BY NEUROLYTIC AGENT, PARAVETEBRAL FACET JOINT NERVE(S) WITH IMAGING GUIDANCE LUMBAR OR SACRAL, SINGLE FACET JOINT	2,008.00	$ 733.00
64495	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE F	2,008.00	N1
28308	OSTEOTOMY, WITH OR WITHOUT LENGTHENING, SHORTENING OR ANGULAR CORRECTION, METATARSAL; OTHER THAN FIRST METATARSAL, EACH	3,900.00	$ 1,260.00

* 2016 Allowables adjusted for Memphis wage index.

Attachment C, Economic Feasibility - 10

Financial Statements

Table of Contents

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, DC 20549

Form 10-K

☒ **Annual report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the fiscal year ended December 31, 2015**

OR

☐ **Transition report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the transition period from to**

Commission File Number 1-7293

TENET HEALTHCARE CORPORATION
(Exact name of Registrant as specified in its charter)

Nevada	**95-2557091**
(State of Incorporation)	(IRS Employer Identification No.)

1445 Ross Avenue, Suite 1400
Dallas, TX 75202
(Address of principal executive offices, including zip code)

(469) 893-2200
(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of each exchange on which registered**
Common stock, $0.05 par value	New York Stock Exchange
6⅞% Senior Notes due 2031	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Exchange Act. Yes ☐ No ☒

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Exchange Act during the preceding 12 months, and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate website every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months. Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of the Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this
Form 10-K. ☒

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company (as defined in Exchange Act Rule 12b-2).

Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Exchange Act Rule 12b-2). Yes ☐ No ☒

As of June 30, 2015, the aggregate market value of the shares of common stock held by non-affiliates of the Registrant (treating directors, executive officers who were SEC reporting persons, and holders of 10% or more of the common stock outstanding as of that date, for this purpose, as affiliates) was approximately $4.8 billion based on the closing price of the Registrant's shares on the New York Stock Exchange on that day. As of January 29, 2016, there were 98,529,352 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive proxy statement for the 2016 annual meeting of shareholders are incorporated by reference into Part III of this Form 10-K.

TABLE OF CONTENTS

PART I.

ITEM 1. BUSINESS

OVERVIEW

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a diversified healthcare services company. We operate regionally focused, integrated healthcare delivery networks, primarily in large urban and suburban markets in the United States. At the core of our networks are acute care and specialty hospitals that, together with our strategically aligned outpatient facilities and related businesses, allow us to provide a comprehensive range of healthcare services in the communities we serve. At December 31, 2015, we operated 86 hospitals, 20 short-stay surgical hospitals, over 475 outpatient centers, nine facilities in the United Kingdom and six health plans through our subsidiaries, partnerships and joint ventures. In addition, our Conifer Holdings, Inc. ("Conifer") subsidiary provides healthcare business process services in the areas of revenue cycle management and technology-enabled performance improvement and health management solutions to health systems, as well as individual hospitals, physician practices, self-insured organizations and health plans.

With respect to our hospitals and outpatient businesses, we seek to offer superior quality and patient services to meet community needs, to make capital and other investments in our facilities and technology, to recruit and retain physicians, and to negotiate competitive contracts with managed care and other private payers. With respect to business process services, we provide comprehensive operational management for revenue cycle functions, including patient access, health information management, revenue integrity and patient financial services. We also offer communication and engagement solutions to optimize the relationship between providers and patients. In addition, Conifer operates a management services business that supports value-based performance through clinical integration, financial risk management and population health management. For financial reporting purposes, our business lines are classified into three separate reportable operating segments – Hospital Operations and other, Ambulatory Care and Conifer. Additional information about our business segments is provided below, and financial and statistical data for the segments can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

In general, we seek to operate our hospitals, ambulatory care and other outpatient centers, and Conifer in a manner that positions them to compete effectively in an evolving healthcare environment. From time to time, we build new hospitals and outpatient centers, and make strategic acquisitions of hospitals, outpatient businesses, physician practices, and other healthcare assets and companies – in each case in markets where we believe our operating strategies can improve performance and create shareholder value. Moreover, we continually evaluate joint venture opportunities with other healthcare providers in our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality services across the care continuum. In furtherance of the foregoing, during the year ended December 31, 2015:

- We combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of United Surgical Partners International, Inc. ("USPI") into a new joint venture ("USPI joint venture"). We have a 50.1% ownership interest in the USPI joint venture, while Welsh, Carson, Anderson & Stowe, a private equity firm that specializes in healthcare investments, owns approximately 47% and Baylor University Medical Center ("Baylor") owns approximately 3% of the joint venture. We significantly increased the number of our not-for-profit partners through USPI and now have relationships with more than 50 leading healthcare systems across the country. Moreover, on December 31, 2015, USPI acquired CareSpot Express Healthcare, which added 35 urgent care centers in Florida and Tennessee to its portfolio of outpatient centers.

- We formed a new joint venture with Baptist Health System, Inc. to own and operate a healthcare network serving Birmingham and central Alabama. We have a 60% ownership interest in the joint

venture, and we manage the network's operations. Baptist Health System contributed four hospitals to the joint venture, and we contributed one hospital. The new network, which also includes each contributed hospital's related businesses, has more than 1,700 licensed beds, nine outpatient centers, 68 physician clinics delivering primary and specialty care, more than 7,000 employees, and approximately 1,500 affiliated physicians.

- We entered into definitive agreements to form two joint ventures with Baylor Scott & White Health ("BSW") involving five North Texas hospitals. Effective January 1, 2016, one of the joint ventures owns or leases and operates Centennial Medical Center, Doctors Hospital at White Rock Lake, Lake Pointe Medical Center and Texas Regional Medical Center at Sunnyvale, all of which were previously owned or leased and operated by certain of our subsidiaries, and the other joint venture owns and operates Baylor Medical Center at Garland, which previously belonged to BSW. The two joint ventures will focus on delivering integrated, value-based care primarily to select communities in Rockwall, Collin and Dallas counties. BSW holds a 75% majority ownership interest in the joint venture that involves our legacy facilities and a 50.1% majority ownership interest in the joint venture that relates to the legacy BSW facility. We own the remaining minority interest in each joint venture and will continue to manage the operations of our legacy facilities. All five hospitals will operate under the BSW brand.

- We formed a new joint venture with Dignity Health and Ascension Arizona to own and operate Carondelet Health Network. We have a 60% ownership interest in the joint venture, and we manage the operations of the network's three hospitals with over 900 licensed beds, related physician practices, ambulatory surgery, imaging and urgent care centers, and other affiliated businesses in Tucson and Nogales, Arizona.

- We acquired European Surgical Partners Ltd. ("Aspen Healthcare" or "Aspen") in the United Kingdom. Although the U.K. provides government-funded healthcare to all of its residents through the National Health Service, the demand for healthcare services exceeds the public system's capacity. Aspen's four acute care hospitals, one cancer center and four outpatient facilities offer patients a complete range of private healthcare and clinical services in a growing market.

- We began operating Hi-Desert Medical Center and its related healthcare facilities under an arrangement structured as a long-term lease agreement with Hi-Desert Memorial Health Care District. We now manage the operations of the 59-bed acute care hospital, as well as a 120-bed skilled nursing facility, an ambulatory surgery center and an imaging center on the hospital's campus in Joshua Tree, California.

- We opened 16 new outpatient facilities, and we acquired 12 other outpatient businesses outside of the corporate development activities described above, as well as various physician practice entities.

- Conifer announced a 10-year extension and expansion of its agreement with Catholic Health Initiatives ("CHI") to provide patient access, revenue integrity and patient financial services to 92 CHI hospitals through 2032. At that time, CHI increased its minority ownership position in Conifer's revenue cycle solutions subsidiary, Conifer Health Solutions, LLC, to approximately 23.8%.

From time to time, we decide to sell, consolidate or close certain facilities to eliminate duplicate services or excess capacity or because of changing market conditions or other factors. During the year ended December 31, 2015, we completed the sale of Saint Louis University Hospital ("SLUH") to Saint Louis University, and we agreed to sell our two North Carolina hospitals – Central Carolina Hospital and Frye Regional Medical Center – and related operations to Duke LifePoint Healthcare (which sale was effective January 1, 2016). In addition, in December 2015, we entered into a definitive agreement for the sale and management of our Atlanta-area hospitals, as well as 26 physician clinics, to WellStar Health System. The transaction is subject to customary regulatory approvals and other closing conditions and is expected to be completed as early as the end of the first quarter of 2016. We also sold or closed nine outpatient centers in the year ended December 31, 2015.

We are committed to providing the communities we serve with high quality, cost-effective healthcare while growing our business, increasing our profitability and creating long-term value for our

shareholders. We believe that our success in increasing our profitability depends in part on our success in executing the strategies and managing the trends discussed in detail in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report. In general, we anticipate the continued influence of major industry trends we have seen emerge over the last several years, and our strategies reflect the belief that: (1) consumers will increasingly select services and providers based on quality and cost; (2) physicians will seek strategic partners with whom they can align clinically; (3) more procedures will shift from the inpatient to the outpatient setting; (4) demand will grow as a result of a strengthening

economy, shifting demographics and the expansion of coverage under the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the "Affordable Care Act" or "ACA"); and (5) payer reimbursements will be constrained and further shift to being more closely tied to performance on quality and service metrics. We believe that our strategies will allow us to achieve our operational and financial targets; however, our ability to execute on these strategies and manage these trends is subject to a number of risks and uncertainties that may cause actual results to be materially different from expectations. Information about risks and uncertainties that could affect our results of operations can be found in "Forward-Looking Statements" below and in Item 1A, Risk Factors, of Part I of this report.

OPERATIONS

HOSPITAL OPERATIONS AND OTHER SEGMENT

Hospitals, Ancillary Outpatient Facilities and Related Businesses—At December 31, 2015, our subsidiaries operated 86 hospitals, including three academic medical centers, two children's hospitals, two specialty hospitals and two critical access hospitals, with a total of 22,525 licensed beds, serving primarily urban and suburban communities in 14 states. Our subsidiaries owned 67 of those hospitals, 12 were owned by entities that are, in turn, jointly owned by a Tenet subsidiary and a strategic partner or group of physicians, and seven were owned by third parties and leased by our subsidiaries. In addition, at December 31, 2015, our subsidiaries operated a long-term acute care hospital and a skilled nursing facility and owned or leased and operated a number of medical office buildings, all of which were located on, or nearby, our hospital campuses. At December 31, 2015, our Hospital Operations and other segment also included: 174 outpatient centers, the majority of which are provider-based diagnostic imaging centers, freestanding urgent care centers, satellite emergency departments and provider-based ambulatory surgery centers; approximately 700 physician practices; and six health plans.

Our hospitals classified in continuing operations for financial reporting purposes generated in excess of 83% of our net operating revenues before provision for doubtful accounts for all periods presented in our Consolidated Financial Statements. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: (1) the business environment, economic conditions and demographics of local communities in which we operate; (2) the number of uninsured and underinsured individuals in local communities treated at our hospitals; (3) seasonal cycles of illness; (4) climate and weather conditions; (5) physician recruitment, retention and attrition; (6) advances in technology and treatments that reduce length of stay; (7) local healthcare competitors; (8) managed care contract negotiations or terminations; (9) the number of patients with high-deductible health insurance plans; (10) any unfavorable publicity about us, which impacts our relationships with physicians and patients; (11) changes in healthcare regulations and the participation of individual states in federal programs; and (12) the timing of elective procedures.

Each of our general hospitals offers acute care services, operating and recovery rooms, radiology services, respiratory therapy services, clinical laboratories and pharmacies; in addition, most have intensive care, critical care and/or coronary care units, physical therapy, and orthopedic, oncology and outpatient services. Many of our hospitals provide tertiary care services, such as open-heart surgery, neonatal intensive care and neurosciences, and some also offer quaternary care in areas such as heart, liver, kidney and bone marrow transplants. Our children's hospitals provide tertiary and quaternary pediatric services, including bone marrow and kidney transplants, as well as burn services. Moreover, a number of our hospitals offer advanced treatment options for patients, including gamma-knife brain surgery and cyberknife radiation therapy for tumors and lesions in the brain, lung, neck, spine and elsewhere that may previously have been considered inoperable or inaccessible by traditional radiation therapy. Many of our hospitals and physician practices also offer a wide range of clinical research studies, giving patients access to innovative care. We are dedicated to helping our hospitals and physicians participate in medical research that is consistent with state and federal regulations and complies with clinical practice guidelines. Clinical research programs relate to a wide array of ailments, including cardiovascular disease, pulmonary disease, musculoskeletal disorders, neurological disorders,

genitourinary disease and various cancers, as well as experimental drug and medical device studies. By supporting clinical research, our hospitals are actively involved in medical advancements that can lead to improvements in patient safety and clinical care.

Except as set forth in the table below, each of our acute care hospitals is accredited by The Joint Commission. With such accreditation, our hospitals are deemed to meet the Medicare Conditions of Participation and are eligible to participate in government-sponsored provider programs, such as the Medicare and Medicaid programs.

The following table lists, by state, the hospitals wholly owned, owned as part of a joint venture or leased and operated by our subsidiaries at December 31, 2015:

Hospital	Location	Licensed Beds	Status
Alabama			
Baptist Medical Center – Princeton[1]	Birmingham	505	JV
Brookwood Medical Center[1]	Birmingham	607	JV
Citizens Baptist Medical Center[1]	Talladega	122	JV
Shelby Baptist Medical Center[1]	Alabaster	252	JV
Walker Baptist Medical Center[1]	Jasper	267	JV
Arizona			
Abrazo Arizona Heart Hospital[2]	Phoenix	59	Owned
Abrazo Arrowhead Campus	Glendale	217	Owned
Abrazo Central Campus	Phoenix	221	Owned
Abrazo Maryvale Campus	Phoenix	232	Owned
Abrazo Scottsdale Campus	Phoenix	136	Owned
Abrazo West Campus	Goodyear	188	Owned
Holy Cross Hospital[3], [4]	Nogales	25	JV
St. Joseph's Hospital[3]	Tucson	486	JV
St. Mary's Hospital[3]	Tucson	400	JV
California			
Desert Regional Medical Center[5]	Palm Springs	385	Leased
Doctors Hospital of Manteca	Manteca	73	Owned
Doctors Medical Center of Modesto	Modesto	461	Owned
Emanuel Medical Center	Turlock	209	Owned
Fountain Valley Regional Hospital & Medical Center	Fountain Valley	400	Owned
Hi-Desert Medical Center[6]	Joshua Tree	179	Leased
John F. Kennedy Memorial Hospital	Indio	145	Owned
Lakewood Regional Medical Center	Lakewood	172	Owned
Los Alamitos Medical Center	Los Alamitos	167	Owned
Placentia Linda Hospital	Placentia	114	Owned
San Ramon Regional Medical Center[7]	San Ramon	123	JV
Sierra Vista Regional Medical Center	San Luis Obispo	164	Owned
Twin Cities Community Hospital	Templeton	122	Owned
Florida			
Coral Gables Hospital	Coral Gables	245	Owned
Delray Medical Center	Delray Beach	493	Owned
Florida Medical Center - a campus of North Shore	Lauderdale Lakes	459	Owned
Good Samaritan Medical Center	West Palm Beach	333	Owned
Hialeah Hospital	Hialeah	378	Owned
North Shore Medical Center	Miami	357	Owned
Palm Beach Gardens Medical Center[8]	Palm Beach Gardens	199	Leased
Palmetto General Hospital	Hialeah	360	Owned
St. Mary's Medical Center	West Palm Beach	464	Owned

West Boca Medical Center	Boca Raton	195	Owned

Hospital	Location	Licensed Beds	Status
Georgia			
Atlanta Medical Center[9]	Atlanta	762	Owned
Atlanta Medical Center – South Campus[9], [10]	East Point	—	Owned
North Fulton Hospital[9], [11]	Roswell	202	Leased
Spalding Regional Hospital[9]	Griffin	160	Owned
Sylvan Grove Hospital[9], [12]	Jackson	25	Leased
Illinois			
Louis A. Weiss Memorial Hospital	Chicago	236	Owned
MacNeal Hospital	Berwyn	368	Owned
West Suburban Medical Center	Oak Park	234	Owned
Westlake Hospital	Melrose Park	230	Owned
Massachusetts			
MetroWest Medical Center – Framingham Union Campus	Framingham	147	Owned
MetroWest Medical Center – Leonard Morse Campus	Natick	152	Owned
Saint Vincent Hospital	Worcester	283	Owned
Michigan			
Children's Hospital of Michigan	Detroit	228	Owned
Detroit Receiving Hospital	Detroit	273	Owned
Harper University Hospital	Detroit	584	Owned
Huron Valley-Sinai Hospital	Commerce Township	158	Owned
Hutzel Women's Hospital[13]	Detroit	—	Owned
Rehabilitation Institute of Michigan[2]	Detroit	97	Owned
Sinai-Grace Hospital	Detroit	404	Owned
Missouri			
Des Peres Hospital	St. Louis	143	Owned
North Carolina			
Central Carolina Hospital[14]	Sanford	137	Owned
Frye Regional Medical Center[14], [15]	Hickory	355	Leased
Pennsylvania			
Hahnemann University Hospital	Philadelphia	496	Owned
St. Christopher's Hospital for Children	Philadelphia	189	Owned
South Carolina			
Coastal Carolina Hospital	Hardeeville	41	Owned
East Cooper Medical Center	Mount Pleasant	140	Owned
Hilton Head Hospital	Hilton Head	93	Owned
Piedmont Medical Center	Rock Hill	288	Owned
Tennessee			
Saint Francis Hospital	Memphis	519	Owned
Saint Francis Hospital – Bartlett	Bartlett	196	Owned

Hospital	Location	Licensed Beds	Status
Texas			
Baptist Medical Center	San Antonio	623	Owned
Centennial Medical Center[16]	Frisco	118	Owned
Cypress Fairbanks Medical Center	Houston	181	Owned
Doctors Hospital at White Rock Lake[17]	Dallas	218	Owned
The Hospitals of Providence East Campus	El Paso	182	Owned
The Hospitals of Providence Memorial Campus	El Paso	480	Owned
The Hospitals of Providence Sierra Campus	El Paso	323	Owned
Houston Northwest Medical Center[18]	Houston	423	JV
Lake Pointe Medical Center[19]	Rowlett	112	JV
Mission Trail Baptist Hospital	San Antonio	110	Owned
Nacogdoches Medical Center	Nacogdoches	153	Owned
North Central Baptist Hospital	San Antonio	387	Owned
Northeast Baptist Hospital	San Antonio	371	Owned
Park Plaza Hospital	Houston	444	Owned
Resolute Health Hospital	New Braunfels	128	Owned
St. Luke's Baptist Hospital	San Antonio	282	Owned
Texas Regional Medical Center at Sunnyvale[20]	Sunnyvale	70	JV/Leased
Valley Baptist Medical Center[21]	Harlingen	586	Owned
Valley Baptist Medical Center – Brownsville[21]	Brownsville	280	Owned
Total Licensed Beds		22,525	

(1) Owned by a limited liability company formed as part of a joint venture with Baptist Health System, Inc., a not-for-profit, faith-based integrated system of doctors, hospitals and other healthcare services in Alabama; a Tenet subsidiary owned a 60% interest in the limited liability company at December 31, 2015, and Baptist Health System, Inc. owned a 40% interest.
(2) Specialty hospital.
(3) Owned by a limited liability company formed as part of a joint venture with Dignity Health and Ascension Arizona, each of which is a not-for-profit, faith-based health system; a Tenet subsidiary owned a 60% interest in the limited liability company at December 31, 2015, Dignity Health owned a 22.5% interest and Ascension Arizona owned a 17.5% interest.
(4) Designated by the Centers for Medicare and Medicaid Services ("CMS") as a critical access hospital.
(5) Lease expires in May 2027.
(6) Lease expires in July 2045.
(7) Owned by a limited liability company formed as part of a joint venture with John Muir Health, a not-for-profit integrated system of doctors, hospitals and other healthcare services in the San Francisco Bay area; a Tenet subsidiary owned a 51% interest in the limited liability company at December 31, 2015, and John Muir Health owned a 49% interest.
(8) Lease expires in February 2017, but may be renewed through at least February 2037, subject to certain conditions contained in the lease.
(9) Subject of a definitive sales agreement with WellStar Health System.
(10) Licensed beds for Atlanta Medical Center – South Campus are presented on a combined basis with Atlanta Medical Center.
(11) Lease expires in February 2020, but may be renewed through at least February 2040, subject to certain conditions contained in the lease.
(12) Designated by CMS as a critical access hospital. Although it has not sought to be accredited, the hospital participates in the Medicare and Medicaid programs by otherwise meeting the Medicare Conditions of Participation. The current lease term for this facility expires in December 2016, but may be renewed through December 2046, subject to certain conditions contained in the lease.
(13) Licensed beds for Hutzel Women's Hospital are presented on a combined basis with Harper University Hospital.
(14) Sold effective January 1, 2016 to Duke LifePoint Healthcare.
(15) Lease expires in February 2022, but may be renewed through at least February 2042, subject to certain conditions contained in the lease.
(16) As of January 1, 2016, managed by a Tenet subsidiary and owned by a limited partnership that is owned by a limited liability partnership (the "JV LLP") formed as part of a joint venture with Baylor Scott & White Health, a not-for-profit healthcare system; a Tenet subsidiary owns a 25% interest in the JV LLP, and BSW owns a 75% interest.
(17) As of January 1, 2016, managed by a Tenet subsidiary and owned by the JV LLP.
(18) Owned by a limited liability company in which a Tenet subsidiary owned an 87.48% interest at December 31, 2015 and is the managing member.
(19) At December 31, 2015, owned by a limited liability company in which a Tenet subsidiary owned a 94.67% interest and was the managing member. As of January 1, 2016, managed by a Tenet subsidiary and owned by a limited liability company in which the JV LLP indirectly owns the 94.67% interest.
(20) At December 31, 2015, leased by a limited liability company in which a Tenet subsidiary owned a 55% interest and was the managing member. As of January 1, 2016, managed by a Tenet subsidiary and leased by a limited liability company in which the JV LLP indirectly owns the 55% interest. The current lease term for this hospital expires in November 2029, but may be renewed through at least November 2049, subject to certain conditions contained in the lease.
(21) At December 31, 2014, Valley Baptist Medical Center and Valley Baptist Medical Center – Brownsville were indirectly owned by a limited liability company formed as part of a joint venture with VB Medical Holdings, a Texas non-profit corporation ("VBMH"); a Tenet subsidiary owned a 51% interest in the limited liability company and was the managing member, and VBMH owned a 49% interest. We subsequently acquired VBMH's 49% interest in the limited liability company pursuant to the terms of the operating agreement governing the joint venture. As a result, we own 100% of both hospitals as of February 11, 2015.

Information regarding the total number of hospitals operated by our subsidiaries, the collective number of licensed beds at those facilities, the utilization of licensed beds and other operating statistics at December 31, 2015, 2014 and 2013 can be found in Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations, of Part II of this report.

At December 31, 2015, our Hospital Operations and other segment also included 69 diagnostic imaging centers, 14 satellite emergency departments, 13 ambulatory surgery centers and seven urgent care centers operated as departments of our hospitals and under the same license, as well as 71 separately licensed, freestanding outpatient centers – typically at locations complementary to our hospitals – consisting of eight diagnostic imaging centers, five emergency departments, three ambulatory surgery centers and 55 urgent care centers, the majority of which are operated under our national MedPost brand. Our subsidiaries wholly own and operate most of the freestanding outpatient centers in our Hospital Operations and other segment. Over 50% of the outpatient centers in our Hospital Operations and other segment at December 31, 2015 were in California, Florida and Texas, the same states where we had the largest concentrations of licensed hospital beds. Strong concentrations of hospital beds and outpatient centers within market areas help us contract more successfully with managed care payers, reduce management, marketing and other expenses, and more efficiently utilize resources. However, these concentrations increase the risk that, should any adverse economic, regulatory, environmental or other condition occur in these areas, our overall business, financial condition, results of operations or cash flows could be materially adversely affected.

Health Plans and Accountable Care Networks—During the year ended December 31, 2015, we operated six health plans with approximately 139,000 members:

- VHS Phoenix Health Plan, Inc. (formerly known as VHS Phoenix Health Plan, LLC), a Medicaid-managed health plan operating as Phoenix Health Plan ("PHP") in Arizona;
- Phoenix Health Plans, Inc. (formerly known as Abrazo Advantage Health Plan, Inc.), a Medicare, Medicaid dual-eligible and public health insurance exchange managed health plan operating in Arizona;
- Golden State Medicare Health Plan, a health maintenance organization ("HMO") that specializes in the care of seniors in Southern California who are eligible for benefits under the Medicare Advantage program;
- Chicago Health System, Inc. ("CHS"), a contracting entity formed to establish a preferred provider network for inpatient and outpatient services provided by MacNeal Hospital, Louis A. Weiss Memorial Hospital and participating physicians in the Chicago area;
- Harbor Health Plan, Inc. (formerly known as ProCare Health Plan, Inc.), a Medicaid-managed, Medicare Advantage and public health insurance exchange health plan operating in Michigan; and
- Allegian Insurance Company (formerly known as Valley Baptist Insurance Company), doing business as Allegian Health Plan, which offers HMO, preferred provider organization ("PPO"), and self-funded products to its members in the form of large group, small group and individual product offerings in south Texas, as well as a Medicare Advantage and public health insurance exchange health plan.

We believe these health plans complement and enhance our market position. Specifically, PHP provides us with insights into state initiatives to manage the Arizona Medicaid population, which is valuable in light of the expansion of health coverage to previously uninsured individuals in the state pursuant to the Affordable Care Act and various other healthcare reform laws. In addition, through CHS, our Chicago-based preferred provider network, we manage capitated contracts covering inpatient, outpatient and physician services. We believe our ownership of CHS allows us to gain additional

experience with risk-bearing contracts and delivery of care in low-cost settings, including our network of health centers.

We also own, control or operate 14 accountable care networks – in Alabama, California, Florida, Georgia, Illinois, Michigan, Missouri, Pennsylvania and Texas – and participate in three additional accountable care networks with other healthcare providers in our markets in Arizona, California and Massachusetts. These networks operate using a

range of payment and delivery models that seek to align provider reimbursement in a way that encourages improved quality metrics and efficiencies in the total cost of care for an assigned population of patients through cooperation of the providers. We believe that our experience operating health plans and accountable care networks gives us a solid framework upon which to build and expand our population health strategies.

AMBULATORY CARE SEGMENT

On June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of United Surgical Partners International, Inc. into our new USPI joint venture. We have a 50.1% ownership interest in the USPI joint venture, while Welsh, Carson, Anderson & Stowe, a private equity firm that specializes in healthcare investments, owns approximately 47% and Baylor University Medical Center owns approximately 3% of the joint venture. In addition, we completed the acquisition of Aspen Healthcare in the United Kingdom on June 16, 2015. In the three months ended June 30, 2015, we began reporting Ambulatory Care as a separate reportable business segment. Our Ambulatory Care segment is comprised of the operations of our USPI joint venture and our Aspen facilities. Our interests in the 49 ambulatory surgery centers and 20 imaging centers we contributed to the USPI joint venture had previously been included in our Hospital Operations and other segment.

USPI's Business—Our USPI joint venture acquires and develops its facilities primarily through the formation of strategic relationships with physicians and health system partners. Subsidiaries of the USPI joint venture hold ownership interests in the facilities directly or indirectly and operate the facilities on a day-to-day basis through management services contracts. We believe that this acquisition and development strategy and operating model will enable our USPI joint venture to continue to grow because of several previously noted industry trends we have seen emerge over the last several years, namely that: (1) consumers will increasingly select services and providers based on quality and cost; (2) physicians will seek strategic partners with whom they can align clinically; (3) more procedures will shift from the inpatient to the outpatient setting; (4) demand will grow as a result of a strengthening economy, shifting demographics and the expansion of coverage under the Affordable Care Act; and (5) payer reimbursements will be constrained and further shift to being more closely tied to performance on quality and service metrics.

The facilities in our USPI joint venture primarily specialize in non-emergency surgical cases and are licensed as ambulatory surgery centers, specialty hospitals or hospitals. We believe surgery centers and surgical hospitals offer many advantages to patients and physicians, including predictability and convenience. Medical emergencies at acute care hospitals often demand the unplanned use of operating rooms and result in the postponement or delay of scheduled surgeries, disrupting physicians' practices and inconveniencing patients. Outpatient facilities generally provide physicians with greater scheduling flexibility, more consistent nurse staffing and faster turnaround time between cases. In addition, many physicians choose to perform surgery in outpatient facilities because their patients prefer the comfort of a less institutional atmosphere and the convenience of simplified admissions and discharge procedures.

New surgical techniques and technology, as well as advances in anesthesia, have significantly expanded the types of surgical procedures that are being performed in surgery centers and have helped drive the growth in outpatient surgery. Improved anesthesia has shortened recovery time by minimizing post-operative side effects, such as nausea and drowsiness, thereby avoiding the need for overnight hospitalization in many cases. Furthermore, some states permit surgery centers to keep a patient for up to 23 hours, which allows for more complex surgeries, previously performed only in an inpatient setting, to be performed in a surgery center.

In addition to these technological and other clinical advancements, a changing payer environment has contributed to the growth of outpatient surgery relative to all surgery performed. Government programs, private insurance companies, managed care organizations and self-insured

employers have implemented cost-containment measures to limit increases in healthcare expenditures, including procedure reimbursement. Furthermore, as self-funded employers are looking to curb annual increases in premiums, they continue to shift additional financial responsibility to patients through higher co-pays, deductibles and premium contributions. These cost-containment measures have contributed to the shift in the delivery of healthcare services away from traditional inpatient hospitals to more cost-effective alternate sites, including short-stay surgical facilities. We believe that surgeries performed at short-stay surgical facilities are generally less expensive than hospital-based outpatient surgeries because of lower facility development

costs, more efficient staffing and space utilization, and a specialized operating environment focused on quality of care and cost containment.

We believe that our USPI joint venture's facilities (1) enhance the quality of care and the healthcare experience of patients, (2) offer a strategic approach for physicians that provides them with significant administrative, clinical and economic benefits, (3) offer a strategic approach for our health system partners to diversify and expand capacity and access within the markets they serve, and (4) offer an efficient and low-cost alternative for payers and employers. We operate our facilities, structure our strategic relationships, and adopt staffing, scheduling, and clinical systems and protocols with the goal of increasing physician productivity. We believe that this focus on physician satisfaction, combined with providing high-quality healthcare in a friendly and convenient environment for patients, will continue to increase the number of procedures performed at our facilities each year. Our strategic relationships enable healthcare systems to offer patients, physicians and payers the cost advantages, convenience and other benefits of ambulatory care in a freestanding facility and, in certain markets, establish networks needed to manage the full continuum of care for a defined population. Further, these relationships allow the healthcare systems to focus their attention and resources on their core business without the challenge of acquiring, developing and operating these facilities.

At December 31, 2015, our USPI joint venture operated 249 ambulatory surgery centers, 20 short-stay surgical hospitals, 20 imaging centers and 35 urgent care centers (acquired from CareSpot Express Healthcare on that date) in 28 states. Of these 324 facilities, 181 are jointly owned with health system partners. Due in large part to these relationships, we do not consolidate the financial results of 139 of the facilities in which our USPI joint venture has an ownership interest, meaning that while we record a share of their net profit within our operating income as equity earnings of unconsolidated affiliates, we do not include their revenues and expenses in the consolidated revenue and expense line items of our consolidated financial statements. For additional information, see Note 1 to our Consolidated Financial Statements.

Aspen's Business—The United Kingdom provides government-funded healthcare to all of its residents through the National Health Service; however, due to funding and capacity limitations, the demand for healthcare services exceeds the public system's capacity. In response to these shortfalls, private healthcare networks and private insurance companies have developed in the U.K. Aspen Healthcare's nine facilities offer patients a complete range of private healthcare and clinical services as described below:

- Cancer Centre London in South West London provides advanced outpatient cancer treatment, including radiotherapy and chemotherapy, as well as a number of related support services; inpatient cancer treatment is provided at our nearby Parkside Hospital.
- The Chelmsford, a private day surgery hospital located northeast of London in Essex, specializes in outpatient and minimally invasive treatment and surgery.
- Claremont Private Hospital, a 41-bed acute care facility in Sheffield, offers an extensive range of inpatient and outpatient services.
- The Edinburgh Clinic, a private surgical hospital in Scotland, offers outpatient procedures and on-site diagnostic imaging.
- Highgate Private Hospital, located in North London, is a 43-bed facility providing a wide range of inpatient and outpatient services.
- The Holly Private Hospital, a 55-bed facility located in Essex, is an acute care inpatient hospital that also offers numerous outpatient services.
- Midland Eye, a private ambulatory surgery center located in West Midlands, provides

specialist eye care and surgery in a dedicated facility.

- Nova Healthcare, a private clinic housed within Leeds Cancer Centre, offers treatment to private patients diagnosed with cancer, blood disorders and a range of neurological diseases.

- Parkside Hospital, located in Wimbledon, a suburb southwest of London, has 69 registered acute care beds and an outpatient surgery unit.

As with our USPI joint venture, a number of Aspen's facilities are owned jointly with physicians and health system partners.

CONIFER SEGMENT

Our Conifer subsidiary provides a number of services primarily to healthcare providers to assist them in generating sustainable improvements in their operating margins, while also enhancing patient, physician and employee satisfaction. At December 31, 2015, Conifer provided one or more of the business process services described below from 20 service centers to more than 800 Tenet and non-Tenet hospital and other clients in over 40 states.

Revenue Cycle Management—Conifer provides comprehensive operational management for patient access, accounts receivable management, health information management, revenue integrity and patient financial services, including:

- centralized insurance and benefit verification, financial clearance, pre-certification, registration and check-in services;

- financial counseling services, including reviews of eligibility for government healthcare programs, for both insured and uninsured patients;

- productivity and quality improvement programs, revenue cycle assessments and optimization recommendations, and The Joint Commission and other preparedness services;

- coding and compliance support, billing assistance, auditing, training, and data management services at every step in the revenue cycle process;

- accounts receivable management, third-party billing and collections; and

- ongoing measurement and monitoring of key revenue cycle metrics.

These revenue cycle management solutions assist hospitals, physician practices and other healthcare organizations in improving cash flow, increasing revenue, and advancing physician and patient satisfaction.

Patient Communications and Engagement Services—Conifer offers customized communications and engagement solutions to optimize the relationship between providers and patients. Conifer's trained customer service representatives provide direct, 24-hour, multilingual support for (1) physician referrals, calls regarding maternity services and other patient inquiries, (2) community education and outreach, (3) scheduling and appointment reminders, and (4) employee recruitment. Conifer also coordinates and implements mail-based marketing programs to keep patients informed of screenings, seminars and other events and services, as well as conducts patient quality and satisfaction surveys to provide valuable feedback to its clients. In addition, Conifer provides clinical admission reviews that are intended to provide evidence-based support for physician decisions on patient status and reduce staffing costs.

Management Services—Conifer also supports value-based performance through clinical integration, financial risk management and population health management, all of which assist hospitals, physicians, accountable care organizations ("ACOs"), health plans, self-insured employers and

FORM 10-Q

TENET HEALTHCARE CORP - THC

Filed: May 02, 2016 (period: March 31, 2016)

Quarterly report with a continuing view of a company's financial position

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, DC 20549

Form 10-Q

☒ **Quarterly report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the quarterly period ended March 31, 2016**

OR

☐ **Transition report pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934 for the transition period from to**

Commission File Number 1-7293

TENET HEALTHCARE CORPORATION

(Exact name of Registrant as specified in its charter)

Nevada	**95-2557091**
(State of Incorporation)	(IRS Employer Identification No.)

1445 Ross Avenue, Suite 1400
Dallas, TX 75202
(Address of principal executive offices, including zip code)

(469) 893-2200
(Registrant's telephone number, including area code)

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months, and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months. Yes ☒ No ☐

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company (as defined in Exchange Act Rule 12b-2).
Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐ Smaller reporting company ☐

Indicate by check mark whether the Registrant is a shell company (as defined in Exchange Act Rule 12b-2). Yes ☐ No ☒

At April 27, 2016, there were 99,304,410 shares of the Registrant's common stock, $0.05 par value, outstanding.

TENET HEALTHCARE CORPORATION
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PART I. FINANCIAL INFORMATION
ITEM 1. FINANCIAL STATEMENTS

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
Dollars in Millions
(Unaudited)

	March 31, 2016	December 31, 2015
ASSETS		
Current assets:		
Cash and cash equivalents	$ 728	$ 356
Accounts receivable, less allowance for doubtful accounts ($901 at March 31, 2016 and $887 at December 31, 2015)	2,807	2,704
Inventories of supplies, at cost	312	309
Income tax receivable	—	7
Assets held for sale	2	550
Other current assets	1,280	1,245
Total current assets	**5,129**	**5,171**
Investments and other assets	1,142	1,175
Deferred income taxes	726	776
Property and equipment, at cost, less accumulated depreciation and amortization ($4,538 at March 31, 2016 and $4,323 at December 31, 2015)	7,961	7,915
Goodwill	7,122	6,970
Other intangible assets, at cost, less accumulated amortization ($701 at March 31, 2016 and $659 at December 31, 2015)	1,686	1,675
Total assets	**$ 23,766**	**$ 23,682**
LIABILITIES AND EQUITY		
Current liabilities:		
Current portion of long-term debt	$ 172	$ 127
Accounts payable	1,228	1,380
Accrued compensation and benefits	772	880
Professional and general liability reserves	161	177
Accrued interest payable	307	205
Liabilities held for sale	—	101
Accrued legal settlement costs	423	294
Other current liabilities	1,205	1,144
Total current liabilities	**4,268**	**4,308**
Long-term debt, net of current portion	14,350	14,383
Professional and general liability reserves	623	578
Defined benefit plan obligations	593	595
Other long-term liabilities	625	594
Total liabilities	**20,459**	**20,458**
Commitments and contingencies		
Redeemable noncontrolling interests in equity of consolidated subsidiaries	2,381	2,266
Equity:		
Shareholders' equity:		
Common stock, $0.05 par value; authorized 262,500,000 shares; 147,692,493 shares issued at March 31, 2016 and 146,920,454 shares issued at December 31, 2015	7	7
Additional paid-in capital	4,804	4,815
Accumulated other comprehensive loss	(160)	(164)
Accumulated deficit	(1,609)	(1,550)
Common stock in treasury, at cost, 48,424,273 shares at March 31, 2016 and 48,425,298 shares at December 31, 2015	(2,417)	(2,417)
Total shareholders' equity	**625**	**691**
Noncontrolling interests	**301**	**267**
Total equity	**926**	**958**
Total liabilities and equity	**$ 23,766**	**$ 23,682**

See accompanying Notes to Condensed Consolidated Financial Statements.

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
Dollars in Millions, Except Per-Share Amounts
(Unaudited)

	Three Months Ended March 31,	
	2016	2015
Net operating revenues:		
Net operating revenues before provision for doubtful accounts	$ 5,420	$ 4,787
Less: Provision for doubtful accounts	376	363
Net operating revenues	**5,044**	**4,424**
Equity in earnings of unconsolidated affiliates	**24**	**4**
Operating expenses:		
Salaries, wages and benefits	2,402	2,125
Supplies	811	687
Other operating expenses, net	1,242	1,093
Electronic health record incentives	—	(6)
Depreciation and amortization	212	207
Impairment and restructuring charges, and acquisition-related costs	28	29
Litigation and investigation costs	173	3
Gains on sales, consolidation and deconsolidation of facilities	(147)	—
Operating income	**347**	**290**
Interest expense	(243)	(199)
Investment earnings	1	—
Net income from continuing operations, before income taxes	**105**	**91**
Income tax expense	(67)	(16)
Net income from continuing operations, before discontinued operations	**38**	**75**
Discontinued operations:		
Loss from operations	(5)	(1)
Litigation and investigation costs	—	3
Income tax benefit (expense)	1	(1)
Net income (loss) from discontinued operations	**(4)**	**1**
Net income	**34**	**76**
Less: Net income attributable to noncontrolling interests	93	29
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ (59)**	**$ 47**
Amounts available (attributable) to Tenet Healthcare Corporation common shareholders		
Net income (loss) from continuing operations, net of tax	$ (55)	$ 46
Net income (loss) from discontinued operations, net of tax	(4)	1
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	**$ (59)**	**$ 47**
Earnings (loss) per share available (attributable) to Tenet Healthcare Corporation common shareholders:		
Basic		
Continuing operations	$ (0.56)	$ 0.47
Discontinued operations	(0.04)	0.01
	$ (0.60)	**$ 0.48**
Diluted		
Continuing operations	$ (0.56)	$ 0.46
Discontinued operations	(0.04)	0.01
	$ (0.60)	**$ 0.47**
Weighted average shares and dilutive securities outstanding (in thousands):		
Basic	98,768	98,699
Diluted	98,768	100,872

See accompanying Notes to Condensed Consolidated Financial Statements.

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF OTHER COMPREHENSIVE INCOME
Dollars in Millions
(Unaudited)

	Three Months Ended March 31,	
	2016	2015
Net income	$ 34	$ 76
Other comprehensive income:		
Amortization of net actuarial loss included in net periodic benefit costs	—	3
Unrealized gains on securities held as available-for-sale	3	1
Foreign currency translation adjustments	2	—
Other comprehensive income before income taxes	5	4
Income tax expense related to items of other comprehensive income	(1)	(1)
Total other comprehensive income, net of tax	4	3
Comprehensive net income	38	79
Less: Comprehensive income attributable to noncontrolling interests	93	29
Comprehensive net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$ (55)	$ 50

See accompanying Notes to Condensed Consolidated Financial Statements.

TENET HEALTHCARE CORPORATION AND SUBSIDIARIES
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
Dollars in Millions
(Unaudited)

	Three Months Ended March 31,	
	2016	2015
Net income	**$ 34**	**$ 76**
Adjustments to reconcile net income to net cash provided by (used in) operating activities:		
Depreciation and amortization	212	207
Provision for doubtful accounts	376	363
Deferred income tax expense	31	12
Stock-based compensation expense	16	15
Impairment and restructuring charges, and acquisition-related costs	28	29
Litigation and investigation costs	173	3
Gains on sales, consolidation and deconsolidation of facilities	(147)	—
Equity in earnings of unconsolidated affiliates, net of distributions received	12	(4)
Amortization of debt discount and debt issuance costs	10	7
Pre-tax loss (income) from discontinued operations	5	(2)
Other items, net	2	(4)
Changes in cash from operating assets and liabilities:		
Accounts receivable	(453)	(484)
Inventories and other current assets	(18)	(74)
Income taxes	28	8
Accounts payable, accrued expenses and other current liabilities	(114)	(200)
Other long-term liabilities	24	28
Payments for restructuring charges, acquisition-related costs, and litigation costs and settlements	**(69)**	**(33)**
Net cash used in operating activities from discontinued operations, excluding income taxes	**(3)**	**(4)**
Net cash provided by (used in) operating activities	**147**	**(57)**
Cash flows from investing activities:		
Purchases of property and equipment — continuing operations	(208)	(184)
Purchases of businesses or joint venture interests, net of cash acquired	(29)	(11)
Proceeds from sales of facilities and other assets	573	—
Proceeds from sales of marketable securities, long-term investments and other assets	12	6
Purchases of equity investments	(18)	—
Other long-term assets	(10)	2
Net cash provided by (used in) investing activities	**320**	**(187)**
Cash flows from financing activities:		
Repayments of borrowings under credit facility	(995)	(690)
Proceeds from borrowings under credit facility	995	820
Repayments of other borrowings	(38)	(32)
Proceeds from other borrowings	1	401
Debt issuance costs	—	(4)
Distributions paid to noncontrolling interests	(44)	(11)
Contributions from noncontrolling interests	—	2
Purchase of noncontrolling interests	—	(254)
Proceeds from exercise of stock options	—	7
Other items, net	(14)	(3)
Net cash provided by (used in) financing activities	**(95)**	**236**
Net increase (decrease) in cash and cash equivalents	372	(8)
Cash and cash equivalents at beginning of period	356	193
Cash and cash equivalents at end of period	**$ 728**	**$ 185**
Supplemental disclosures:		
Interest paid, net of capitalized interest	$ (132)	$ (117)
Income tax refunds (payments), net	$ (6)	$ 1

See accompanying Notes to Condensed Consolidated Financial Statements.

TENET HEALTHCARE CORPORATION
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1. BASIS OF PRESENTATION

Description of Business and Basis of Presentation

Tenet Healthcare Corporation (together with our subsidiaries, referred to herein as "Tenet," "we" or "us") is a diversified healthcare services company. At March 31, 2016, we operated 84 hospitals, 20 short-stay surgical hospitals, over 475 outpatient centers, nine facilities in the United Kingdom and six health plans through our subsidiaries, partnerships and joint ventures, including USPI Holding Company, Inc. ("USPI joint venture"). The results of 142 of these facilities, in which we hold noncontrolling interests, are recorded using the equity method of accounting. Our Conifer Holdings, Inc. ("Conifer") subsidiary provides healthcare business process services in the areas of revenue cycle management and technology-enabled performance improvement and health management solutions to health systems, as well as individual hospitals, physician practices, self-insured organizations and health plans.

This quarterly report supplements our Annual Report on Form 10-K for the year ended December 31, 2015 ("Annual Report"). As permitted by the Securities and Exchange Commission for interim reporting, we have omitted certain notes and disclosures that substantially duplicate those in our Annual Report. For further information, refer to the audited Consolidated Financial Statements and notes included in our Annual Report. Unless otherwise indicated, all financial and statistical data included in these notes to our Condensed Consolidated Financial Statements relate to our continuing operations, with dollar amounts expressed in millions (except per-share amounts). Certain prior-year amounts have been reclassified to conform to the current-year presentation.

Although the Condensed Consolidated Financial Statements and related notes within this document are unaudited, we believe all adjustments considered necessary for a fair presentation have been included and are of a normal recurring nature. In preparing our financial statements in conformity with accounting principles generally accepted in the United States of America ("GAAP"), we are required to make estimates and assumptions that affect the amounts reported in our Condensed Consolidated Financial Statements and these accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable given the particular circumstances in which we operate. Actual results may vary from those estimates. Financial and statistical information we report to other regulatory agencies may be prepared on a basis other than GAAP or using different assumptions or reporting periods and, therefore, may vary from amounts presented herein. Although we make every effort to ensure that the information we report to those agencies is accurate, complete and consistent with applicable reporting guidelines, we cannot be responsible for the accuracy of the information they make available to the public.

Operating results for the three month period ended March 31, 2016 are not necessarily indicative of the results that may be expected for the full year. Reasons for this include, but are not limited to: overall revenue and cost trends, particularly the timing and magnitude of price changes; fluctuations in contractual allowances and cost report settlements and valuation allowances; managed care contract negotiations, settlements or terminations and payer consolidations; changes in Medicare and Medicaid regulations; Medicaid and other supplemental funding levels set by the states in which we operate; the timing of approval by the Centers for Medicare and Medicaid Services of Medicaid provider fee revenue programs; trends in patient accounts receivable collectability and associated provisions for doubtful accounts; fluctuations in interest rates; levels of malpractice insurance expense and settlement trends; the number of covered lives managed by our health plans and the plans' ability to effectively manage medical costs; the timing of when we meet the criteria to recognize electronic health record incentives; impairment of long-lived assets and goodwill; restructuring charges; losses, costs and insurance recoveries related to natural disasters and other weather-related occurrences; litigation and investigation costs; acquisitions and dispositions of facilities and other assets; income tax rates and deferred tax asset valuation allowance activity; changes in estimates of accruals for annual incentive compensation; the timing and amounts of stock option and restricted stock unit grants to employees and directors; gains or losses from early extinguishment of debt; and changes in occupancy levels and patient volumes. Factors that affect patient volumes and, thereby, the results of operations at our hospitals and related healthcare facilities include, but are not limited to: the business environment, economic conditions and demographics of local communities in which we operate; the number of

uninsured and underinsured individuals in local communities treated at our hospitals; seasonal cycles of illness; climate and weather conditions; physician recruitment, retention and attrition; advances in technology and treatments that reduce length of stay; local healthcare competitors; managed care contract negotiations or terminations; the number of patients with high-deductible health insurance plans; any unfavorable publicity about us, or our joint venture partners, that impacts our relationships with physicians and patients; changes in healthcare regulations and the participation of individual states in federal programs; and the timing of elective procedures. These considerations apply to year-to-year comparisons as well.

Translation of Foreign Currencies

The accounts of European Surgical Partners, Limited ("Aspen") were measured in its local currency (the pound sterling) and then translated into U.S. dollars. All assets and liabilities were translated using the current rate of exchange at the balance sheet date. Results of operations were translated using the average rates prevailing throughout the period of operations. Translation gains or losses resulting from changes in exchange rates are accumulated in shareholders' equity.

Net Operating Revenues Before Provision for Doubtful Accounts

We recognize net operating revenues before provision for doubtful accounts in the period in which our services are performed. Net operating revenues before provision for doubtful accounts primarily consist of net patient service revenues that are recorded based on established billing rates (i.e., gross charges), less estimated discounts for contractual and other allowances, principally for patients covered by Medicare, Medicaid, managed care and other health plans, as well as certain uninsured patients under our *Compact with Uninsured Patients* ("Compact") and other uninsured discount and charity programs.

The table below shows the sources of net operating revenues before provision for doubtful accounts from continuing operations:

	Three Months Ended March 31,	
	2016	2015
General Hospitals:		
Medicare	$ 859	$ 898
Medicaid	373	385
Managed care	2,626	2,405
Indemnity, self-pay and other	437	414
Acute care hospitals — other revenue	7	15
Other:		
Other operations	1,118	670
Net operating revenues before provision for doubtful accounts	**$ 5,420**	**$ 4,787**

Cash and Cash Equivalents

We treat highly liquid investments with original maturities of three months or less as cash equivalents. Cash and cash equivalents were approximately $728 million and $356 million at March 31, 2016 and December 31, 2015, respectively. At March 31, 2016 and December 31, 2015, our book overdrafts were approximately $256 million and $301 million, respectively, which were classified as accounts payable.

At March 31, 2016 and December 31, 2015, approximately $175 million and $171 million, respectively, of total cash and cash equivalents in the accompanying Condensed Consolidated Balance Sheets were intended for the operations of our captive insurance subsidiaries and our health plans.

Also at March 31, 2016 and December 31, 2015, we had $110 million and $133 million, respectively, of property and equipment purchases accrued for items received but not yet paid. Of these amounts, $63 million and $95 million, respectively, were included in accounts payable.

During the three months ended March 31, 2016 and 2015, we entered into non-cancellable capital leases of approximately $31 million and $33 million, respectively, primarily for buildings and equipment.

Other Intangible Assets

The following tables provide information regarding other intangible assets, which are included in the accompanying Condensed Consolidated Balance Sheets at March 31, 2016 and December 31, 2015:

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At March 31, 2016:			
Capitalized software costs	$ 1,495	$ (625)	$ 870
Trade names	106	—	106
Contracts	669	(30)	639
Other	117	(46)	71
Total	**$ 2,387**	**$ (701)**	**$ 1,686**

	Gross Carrying Amount	Accumulated Amortization	Net Book Value
At December 31, 2015:			
Capitalized software costs	$ 1,456	$ (594)	$ 862
Trade names	106	—	106
Contracts	653	(26)	627
Other	119	(39)	80
Total	**$ 2,334**	**$ (659)**	**$ 1,675**

Estimated future amortization of intangibles with finite useful lives at March 31, 2016 is as follows:

		Years Ending December 31,					
	Total	2016	2017	2018	2019	2020	Later Years
Amortization of intangible assets	$ 1,207	$ 141	$ 174	$ 146	$ 122	$ 89	$ 535

Investments in Unconsolidated Affiliates

We control 213 of the facilities operated by our Ambulatory Care segment and, therefore, consolidate their results (211 are consolidated within our Ambulatory Care segment and two are consolidated within our Hospital Operations and other segment). We account for many of the facilities our Ambulatory Care segment operates (122 of 335 at March 31, 2016) and four of the hospitals our Hospital Operations and other segment operates under the equity method as investments in unconsolidated affiliates and report only our share of net income attributable to the investee as equity in earnings of unconsolidated affiliates in the accompanying Condensed Consolidated Statements of Operations. Summarized financial information for these equity method investees is included in the following table.

	Three Months Ended March 31, 2016
Net operating revenues	$ 578
Net income	$ 105
Net income attributable to the investees	$ 69

NOTE 2. ACCOUNTS RECEIVABLE AND ALLOWANCE FOR DOUBTFUL ACCOUNTS

The principal components of accounts receivable are shown in the table below:

	March 31, 2016	December 31, 2015
Continuing operations:		
Patient accounts receivable	$ 3,606	$ 3,486
Allowance for doubtful accounts	(901)	(887)
Estimated future recoveries from accounts assigned to our Conifer subsidiary	146	144
Net cost reports and settlements payable and valuation allowances	(47)	(42)
	2,804	2,701
Discontinued operations	3	3
Accounts receivable, net	**$ 2,807**	**$ 2,704**

At March 31, 2016 and December 31, 2015, our allowance for doubtful accounts was 25.0% and 25.4%, respectively, of our patient accounts receivable. Accounts that are pursued for collection through Conifer's regional business offices are maintained on our hospitals' books and reflected in patient accounts receivable with an allowance for doubtful accounts established to reduce the carrying value of such receivables to their estimated net realizable value. Generally, we estimate this allowance based on the aging of our accounts receivable by hospital, our historical collection experience by hospital and for each type of payer, and other relevant factors. At March 31, 2016 and December 31, 2015, our allowance for doubtful accounts for self-pay was 81.2% and 80.6%, respectively, of our self-pay patient accounts receivable, including co-pays and deductibles owed by patients with insurance. At March 31, 2016 and December 31, 2015, our allowance for doubtful accounts for managed care was 8.4% and 7.5%, respectively, of our managed care patient accounts receivable.

We also provide charity care to patients who are financially unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid disproportionate share hospital ("DSH") payments. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. The table below shows our estimated costs (based on selected operating expenses, which include salaries, wages and benefits, supplies and other operating expenses) of caring for our self-pay patients and charity care patients, and revenues attributable to Medicaid DSH and other supplemental revenues we recognized in three months ended March 31, 2016 and 2015.

	Three Months Ended March 31,	
	2016	2015
Estimated costs for:		
Self-pay patients	$ 165	$ 164
Charity care patients	$ 44	$ 36
Medicaid DSH and other supplemental revenues	$ 227	$ 247

At March 31, 2016 and December 31, 2015, we had approximately $450 million and $387 million, respectively, of receivables recorded in other current assets and approximately $174 million and $139 million, respectively, of payables recorded in other current liabilities in the accompanying Condensed Consolidated Balance Sheets related to California's provider fee program.

NOTE 3. ASSETS AND LIABILITIES HELD FOR SALE

Our hospitals, physician practices and related assets in Georgia met the criteria to be classified as assets held for sale in the three months ended June 30, 2015. In accordance with the guidance in the Financial Accounting Standards Board's Accounting Standards Codification ("ASC") 360, "Property, Plant and Equipment," we classified $549 million of

our assets in Georgia as "assets held for sale" in current assets and $101 million of our liabilities in Georgia as "liabilities held for sale" in current liabilities in the accompanying Condensed Consolidated Balance Sheet at December 31, 2015. We completed the sale of our Georgia assets on March 31, 2016 at a transaction price of approximately $575 million and recognized a gain on sale of approximately $113 million. Because we did not sell the related accounts receivable related to the pre-closing period, net receivables of approximately $141 million are included in accounts receivable, less allowance for doubtful accounts in the accompanying Condensed Consolidated Balance Sheet at March 31, 2016.

NOTE 4. IMPAIRMENT AND RESTRUCTURING CHARGES, AND ACQUISITION-RELATED COSTS

During the three months ended March 31, 2016, we recorded impairment and restructuring charges and acquisition-related costs of $28 million primarily related to our Hospital Operations and other segment, consisting of approximately $2 million to write-down other intangible assets, $10 million of employee severance costs, $1 million of restructuring costs, $1 million of contract and lease termination fees, and $14 million in acquisition-related costs, which include $5 million of transaction costs and $9 million of acquisition integration charges.

During the three months ended March 31, 2015, we recorded impairment and restructuring charges and acquisition-related costs of $29 million, consisting of $6 million of employee severance costs, $3 million of restructuring costs, and $20 million in acquisition-related costs, which include $7 million of transaction costs and $13 million of acquisition integration charges.

Our impairment tests presume stable, improving or, in some cases, declining operating results in our facilities, which are based on programs and initiatives being implemented that are designed to achieve the facility's most recent projections. If these projections are not met, or if in the future negative trends occur that impact our future outlook, impairments of long-lived assets and goodwill may occur, and we may incur additional restructuring charges, which could be material.

At March 31, 2016, our continuing operations consisted of three reportable segments, Hospital Operations and other, Ambulatory Care and Conifer. Within our Hospital Operations and other segment, our regions and markets are reporting units used to perform our goodwill impairment analysis and are one level below our reportable business segment level. Our Ambulatory Care segment consists of the operations of our USPI joint venture and our Aspen facilities.

Our Hospital Operations and other segment was structured as follows at March 31, 2016:

- Our Florida region included all of our hospitals and other operations in Florida;
- Our Northeast region included all of our hospitals and other operations in Illinois, Massachusetts and Pennsylvania;
- Our Southern region included all of our hospitals and other operations in Alabama, Georgia, South Carolina and Tennessee;
- Our Texas region included all of our hospitals and other operations in Missouri, New Mexico and Texas;
- Our Western region included all of our hospitals and other operations in Arizona and California; and
- Our Detroit market included all of our hospitals and other operations in the Detroit, Michigan area.

We periodically incur costs to implement restructuring efforts for specific operations, which are recorded in our statement of operations as they are incurred. Our restructuring plans focus on various aspects of operations, including aligning our operations in the most strategic and cost-effective structure. Certain restructuring and acquisition-related costs are based on estimates. Changes in estimates are recognized as they occur.

NOTE 5. LONG-TERM DEBT AND LEASE OBLIGATIONS

The table below shows our long-term debt at March 31, 2016 and December 31, 2015:

	March 31, 2016	December 31, 2015
Senior notes:		
5%, due 2019	$ 1,100	$ 1,100
5½%, due 2019	500	500
6¾%, due 2020	300	300
8%, due 2020	750	750
8⅛%, due 2022	2,800	2,800
6¾%, due 2023	1,900	1,900
6⅞%, due 2031	430	430
Senior secured notes:		
6¼%, due 2018	1,041	1,041
4¾%, due 2020	500	500
6%, due 2020	1,800	1,800
Floating % due 2020	900	900
4½%, due 2021	850	850
4⅜%, due 2021	1,050	1,050
Capital leases and mortgage notes	853	852
Unamortized issue costs, note discounts and premium	(252)	(263)
Total long-term debt	**14,522**	**14,510**
Less current portion	172	127
Long-term debt, net of current portion	**$ 14,350**	**$ 14,383**

Credit Agreement

On December 4, 2015, we entered into an amendment to our existing senior secured revolving credit facility (as amended, "Credit Agreement") in order to, among other things, extend the scheduled maturity date of the facility, reduce the rates of certain interest and fees payable under the facility, and remove certain restrictions with respect to the borrowing base eligibility of certain accounts receivable. The Credit Agreement provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. The Credit Agreement, which has a scheduled maturity date of December 4, 2020, is collateralized by patient accounts receivable of substantially all of our domestic wholly owned hospitals. In addition, borrowings under the Credit Agreement are guaranteed by substantially all of our wholly owned domestic hospital subsidiaries. Outstanding revolving loans accrue interest at a base rate plus a margin ranging from 0.25% to 0.75% per annum or the London Interbank Offered Rate ("LIBOR") plus a margin ranging from 1.25% to 1.75% per annum, in each case based on available credit. An unused commitment fee payable on the undrawn portion of the revolving loans ranges from 0.25% to 0.375% per annum based on available credit. Our borrowing availability is based on a specified percentage of eligible accounts receivable, including self-pay accounts. At March 31, 2016, we had no cash borrowings outstanding under the Credit Agreement, and we had approximately $4 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $996 million was available for borrowing under the Credit Agreement at March 31, 2016.

Letter of Credit Facility

On March 7, 2014, we entered into a letter of credit facility agreement ("LC Facility") that provides for the issuance of standby and documentary letters of credit (including certain letters of credit issued under our prior credit agreement, which we transferred to the LC Facility (the "Preexisting Letters of Credit")), from time to time, in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). The LC Facility has a scheduled maturity date of March 7, 2017, and obligations thereunder are guaranteed by and secured by a first priority pledge of the capital stock and other ownership interests of certain of our domestic hospital subsidiaries on an equal ranking basis with our existing senior secured notes.

Drawings under any letter of credit issued under the LC Facility (including the Preexisting Letters of Credit) that we have not reimbursed within three business days after notice thereof will accrue interest at a base rate plus a margin equal to 0.875% per annum. An unused commitment fee is payable at an initial rate of 0.50% per annum with a step down to 0.375% per annum based on the secured debt to EBITDA ratio of 3.00 to 1.00. A per annum fee on the aggregate outstanding amount of issued but undrawn letters of credit (including the Preexisting Letters of Credit) will accrue at a rate of 1.875% per annum. An issuance fee equal to 0.125% per annum of the aggregate face amount of each outstanding letter of credit is payable to the account of the issuer of the related letter of credit. At March 31, 2016, we had approximately $139 million of standby letters of credit outstanding under the LC Facility.

NOTE 6. GUARANTEES

At March 31, 2016, the maximum potential amount of future payments under our income guarantees to certain physicians who agree to relocate and revenue collection guarantees to hospital-based physician groups providing certain services at our hospitals was $89 million. We had a total liability of $75 million recorded for these guarantees included in other current liabilities at March 31, 2016.

At March 31, 2016, we also had issued guarantees of the indebtedness and other obligations of our investees to third parties, the maximum potential amount of future payments under which was approximately $35 million. Of the total, $17 million relates to the obligations of consolidated subsidiaries, which obligations are recorded in the accompanying Condensed Consolidated Balance Sheet at March 31, 2016.

NOTE 7. EMPLOYEE BENEFIT PLANS

At March 31, 2016, approximately 1.7 million shares of common stock were available under our 2008 Stock Incentive Plan for future stock option grants and other incentive awards, including restricted stock units. Options have an exercise price equal to the fair market value of the shares on the date of grant and generally expire 10 years from the date of grant. A restricted stock unit is a contractual right to receive one share of our common stock or the equivalent value in cash in the future. Options and time-based restricted stock units typically vest one-third on each of the first three anniversary dates of the grant; however, certain special retention awards may have longer vesting periods. In addition, we grant performance-based restricted stock units (and, in prior years, have granted performance-based options) that vest subject to the achievement of specified performance goals within a specified timeframe.

Our Condensed Consolidated Statements of Operations for the three months ended March 31, 2016 and 2015 include $14 million and $18 million, respectively, of pretax compensation costs related to our stock-based compensation arrangements recorded in salaries, wages and benefits.

Stock Options

The following table summarizes stock option activity during the three months ended March 31, 2016:

	Options	Weighted Average Exercise Price Per Share	Aggregate Intrinsic Value (In Millions)	Weighted Average Remaining Life
Outstanding at December 31, 2015	1,606,842	$ 22.87		
Granted	—	—		
Exercised	(3,950)	4.56		
Forfeited/Expired	(29,392)	4.56		
Outstanding at March 31, 2016	**1,573,500**	**22.75**	**$ 13**	**2.9 years**
Vested and expected to vest at March 31, 2016	**1,573,500**	**$ 22.75**	**$ 13**	**2.9 years**
Exercisable at March 31, 2016	**1,573,500**	**$ 22.75**	**$ 13**	**2.9 years**

There were 3,950 stock options exercised during the three months ended March 31, 2016 with an aggregate intrinsic value of less than $1 million, and 77,658 stock options exercised during the same period in 2015 with a less than $1 million aggregate intrinsic value.

At March 31, 2016, there were no unrecognized compensation costs related to stock options. Also, there were no stock options granted in the three months ended March 31, 2016 or 2015.

The following table summarizes information about our outstanding stock options at March 31, 2016:

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number of Options	Weighted Average Remaining Contractual Life	Weighted Average Exercise Price	Number of Options	Weighted Average Exercise Price
$0.00 to $4.569	202,152	2.9 years	$ 4.56	202,152	$ 4.56
$4.57 to $25.089	910,897	3.6 years	20.99	910,897	20.99
$25.09 to $32.569	182,000	0.9 years	26.40	182,000	26.40
$32.57 to $42.529	278,451	1.8 years	39.31	278,451	39.31
	1,573,500	**2.9 years**	**$ 22.75**	**1,573,500**	**$ 22.75**

Restricted Stock Units

The following table summarizes restricted stock unit activity during the three months ended March 31, 2016:

	Restricted Stock Units	Weighted Average Grant Date Fair Value Per Unit
Unvested at December 31, 2015	3,627,232	$ 44.69
Granted	1,231,727	31.08
Vested	(1,223,015)	43.68
Forfeited	(23,639)	45.05
Unvested at March 31, 2016	**3,612,305**	**$ 40.38**

In the three months ended March 31, 2016, we granted 474,052 restricted stock units subject to time-vesting, of which 458,379 will vest and be settled ratably over a three-year period from the grant date, and 15,673 will vest and be settled on the third anniversary of the grant date. In January 2016, following the appointment of two new members of our Board of Directors, we also made initial grants totaling 5,084 restricted stock units to these directors, as well as prorated annual grants totaling 5,614 restricted stock units. Both the initial grants and the annual grants vested immediately, however the initial grants will not settle until the directors' separation from the Board, while the annual grants settle on the third anniversary of the grant date. In addition, we granted 455,437 performance-based restricted stock units to certain of our senior officers; the vesting of these restricted stock units is contingent on our achievement of specified three-year performance goals for the years 2016 to 2018. Provided the goals are achieved, the performance-based restricted stock units will vest and settle on the third anniversary of the grant date. The actual number of performance-based restricted stock units that could vest will range from 0% to 200% of the 455,437 units granted, depending on our level of achievement with respect to the performance goals. Moreover, in the three months ended March 31, 2016, we granted 291,540 restricted stock units as a result of our level of achievement with respect to prior-year target performance goals.

At March 31, 2016, there were $117 million of total unrecognized compensation costs related to restricted stock units. These costs are expected to be recognized over a weighted average period of 2.3 years.

NOTE 8. EQUITY

Changes in Shareholders' Equity

The following table shows the changes in consolidated equity during the three months ended March 31, 2016 and 2015 (dollars in millions, share amounts in thousands):

	Tenet Healthcare Corporation Shareholders' Equity							
	Common Stock		Additional Paid-In Capital	Accumulated Other Comprehensive Loss	Accumulated Deficit	Treasury Stock	Noncontrolling Interests	Total Equity
	Shares Outstanding	Issued Par Amount						
Balances at December 31, 2015	98,495	$ 7	$ 4,815	$ (164)	$ (1,550)	$ (2,417)	$ 267	$ 958
Net income (loss)	—	—	—	—	(59)	—	13	(46)
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(10)	(10)
Contributions from noncontrolling interests	—	—	—	—	—	—	10	10
Other comprehensive income	—	—	—	4	—	—	—	4
Purchases (sales) of businesses and noncontrolling interests	—	—	(7)	—	—	—	21	14
Stock-based compensation expense, tax benefit and issuance of common stock	773	—	(4)	—	—	—	—	(4)
Balances at March 31, 2016	99,268	$ 7	$ 4,804	$ (160)	$ (1,609)	$ (2,417)	$ 301	$ 926
Balances at December 31, 2014	98,382	$ 7	$ 4,614	$ (182)	$ (1,410)	$ (2,378)	$ 134	$ 785
Net income	—	—	—	—	47	—	8	55
Distributions paid to noncontrolling interests	—	—	—	—	—	—	(10)	(10)
Contributions from noncontrolling interests	—	—	—	—	—	—	1	1
Other comprehensive income	—	—	—	3	—	—	—	3
Purchases (sales) of businesses and noncontrolling interests	—	—	129	—	—	—	—	129
Stock-based compensation expense and issuance of common stock	782	—	8	—	—	1	—	9
Balance at March 31, 2015	99,164	$ 7	$ 4,751	$ (179)	$ (1,363)	$ (2,377)	$ 133	$ 972

NOTE 9. PROPERTY AND PROFESSIONAL AND GENERAL LIABILITY INSURANCE

Property Insurance

We have property, business interruption and related insurance coverage to mitigate the financial impact of catastrophic events or perils that is subject to deductible provisions based on the terms of the policies. These policies are on an occurrence basis.

Professional and General Liability Reserves

At March 31, 2016 and December 31, 2015, the aggregate current and long-term professional and general liability reserves in our accompanying Condensed Consolidated Balance Sheets were approximately $784 million and $755 million, respectively. These reserves include the reserves recorded by our captive insurance subsidiaries and our self-insured retention reserves recorded based on modeled estimates for the portion of our professional and general liability risks, including incurred but not reported claims, for which we do not have insurance coverage. We estimated the reserves for losses and related expenses using expected loss-reporting patterns discounted to their present value under a risk-free rate approach using a Federal Reserve seven-year maturity rate of 1.54% at March 31, 2016 and 2.09% at December 31, 2015.

If the aggregate limit of any of our professional and general liability policies is exhausted, in whole or in part, it could deplete or reduce the limits available to pay any other material claims applicable to that policy period.

Included in other operating expenses, net, in the accompanying Condensed Consolidated Statements of Operations is malpractice expense of $93 million and $89 million for the three months ended March 31, 2016 and 2015, respectively.

NOTE 10. CLAIMS AND LAWSUITS

We operate in a highly regulated and litigious industry. As a result, we commonly become involved in disputes, litigation and regulatory matters incidental to our operations, including governmental investigations, personal injury lawsuits, employment claims and other matters arising out of the normal conduct of our business.

We record accruals for estimated losses relating to claims and lawsuits when available information indicates that a loss is probable and we can reasonably estimate the amount of the loss or a range of loss. Significant judgment is required in both the determination of the probability of a loss and the determination as to whether a loss is reasonably estimable. These determinations are updated at least quarterly and are adjusted to reflect the effects of negotiations, settlements, rulings, advice of legal counsel and technical experts, and other information and events pertaining to a particular matter. If a loss on a material matter is reasonably possible and estimable, we disclose an estimate of the loss or a range of loss. In cases where we have not disclosed an estimate, we have concluded that the loss is either not reasonably possible or the loss, or a range of loss, is not reasonably estimable, based on available information.

Governmental Reviews and Lawsuits

Healthcare companies are subject to numerous investigations by various governmental agencies. Further, private parties have the right to bring qui tam or "whistleblower" lawsuits against companies that allegedly submit false claims for payments to, or improperly retain overpayments from, the government and, in some states, private payers. We and our subsidiaries have received inquiries in recent years from government agencies, and we may receive similar inquiries in future periods. The following matters are pending.

- *Clinica de la Mama Qui Tam Action and Criminal Investigation*—As previously disclosed, we and four of our hospital subsidiaries are defendants in civil qui tam litigation (*United States of America, ex rel. Ralph D. Williams v. Health Management Associates, Inc., et al.*) that alleges that the contractual arrangements entered into by the hospital subsidiaries with Hispanic Medical Management, Inc. ("HMM") violated the federal and state anti-kickback statutes and false claims acts. HMM owned and operated clinics that provided, among other things, prenatal care predominantly to uninsured patients. Beginning in 2000, the hospital subsidiaries contracted with HMM for translation, marketing, management and Medicaid eligibility determination services. Subsequently, the Georgia Attorney General's Office and the U.S. Attorney's Office intervened in the qui tam action. Effective March 31, 2016, we sold the operating assets of three of the four hospital subsidiaries; however, we retained any potential liabilities arising from the litigation or the U.S. Department of Justice ("DOJ") investigation discussed below.

  If the plaintiff in the pending civil litigation were to prevail, the potential sanctions could include up to three times the reimbursement of relevant government program payments received by the four hospital subsidiaries for uninsured HMM patients treated at the hospitals, the assessment of civil penalties and potential exclusion from participation in federal healthcare programs.

  Also as previously disclosed, the DOJ has been conducting a criminal investigation of us, certain of our subsidiaries and former employees with respect to the contractual arrangements between HMM and the four hospitals. We are cooperating in the investigation and have responded, and continue to respond, to document and other requests pursuant to subpoenas issued to us and the four subsidiaries.

  In January 2016, we commenced discussions with the DOJ and the State of Georgia regarding potential resolution of the qui tam action and criminal investigation. In the three months ended March 31, 2016, we increased the aggregate accrual for these matters from $238 million to $407 million to reflect the most recent offer we made on April 25, 2016 to resolve the criminal investigation and civil litigation. The offer was not accepted, but the parties continue to engage in discussions to resolve these matters. There can be no assurance that ongoing discussions will lead to a resolution. The terms of a final resolution of these matters may require us to pay significant fines and penalties and give rise to other costs or adverse consequences that materially exceed the accrual we have established. Based on the ongoing uncertainties and potentially wide range of

outcomes associated with any potential resolution, we cannot estimate the amount of potential loss or range of reasonably possible loss in excess of the amount accrued that we may face.

In addition to the payment of a monetary penalty, the final terms of any resolution of these matters could include: (i) the execution by the Company of a Corporate Integrity Agreement or a non-prosecution agreement, which may provide for the appointment of a corporate monitor and ongoing compliance audits; (ii) a deferred prosecution agreement by an intermediate subsidiary of the Company; and (iii) a commitment that one or more of the hospital subsidiaries subject to the investigation and proceedings enter into a guilty plea. The non-monetary terms of any resolution could expose us to increased operating costs, reputational harm, administrative burdens, and diminished profits and revenues.

If our efforts to negotiate a settlement ultimately are unsuccessful, and we or our subsidiaries are determined to have violated the federal anti-kickback statute, the sanctions could include fines, which could be significant, and mandatory exclusion from participation in federal healthcare programs.

To the extent that either the civil or criminal matter discussed above is determined adversely to our interests, such determination could have a material adverse effect on our business, financial condition, results of operations or cash flows.

Antitrust Class Action Lawsuit Filed by Registered Nurses in San Antonio

In *Maderazo, et al. v. VHS San Antonio Partners, L.P. d/b/a Baptist Health Systems, et al.*, filed in June 2006 in the U.S. District Court for the Western District of Texas, a purported class of registered nurses employed by three unaffiliated San Antonio-area hospital systems allege those hospital systems, including Baptist Health System, and other unidentified San Antonio regional hospitals violated Section §1 of the federal Sherman Act by conspiring to depress nurses' compensation and exchanging compensation-related information among themselves in a manner that reduced competition and suppressed the wages paid to such nurses. The suit seeks unspecified damages (subject to trebling under federal law), interest, costs and attorneys' fees. The case had been stayed since 2008; however, in July 2015, the court lifted the stay and re-opened discovery. Because these proceedings are at an early stage, it is impossible at this time to predict their outcome with any certainty; however, we believe that the ultimate resolution of this matter will not have a material effect on our business, financial condition or results of operations. We will continue to seek to defeat class certification and vigorously defend ourselves against the plaintiffs' allegations.

Ordinary Course Matters

We are also subject to other claims and lawsuits arising in the ordinary course of business, including potential claims related to, among other things, the care and treatment provided at our hospitals and outpatient facilities, the application of various federal and state labor laws, tax audits and other matters. Although the results of these claims and lawsuits cannot be predicted with certainty, we believe that the ultimate resolution of these ordinary course claims and lawsuits will not have a material effect on our business or financial condition.

New claims or inquiries may be initiated against us from time to time. These matters could (1) require us to pay substantial damages or amounts in judgments or settlements, which, individually or in the aggregate, could exceed amounts, if any, that may be recovered under our insurance policies where coverage applies and is available, (2) cause us to incur substantial expenses, (3) require significant time and attention from our management, and (4) cause us to close or sell hospitals or otherwise modify the way we conduct business.

The table below presents reconciliations of the beginning and ending liability balances in connection with legal settlements and related costs recorded during the three months ended March 31, 2016 and 2015:

	Balances at Beginning of Period	Litigation and Investigation Costs	Cash Payments	Balances at End of Period
Three Months Ended March 31, 2016				
Continuing operations	$ 299	$ 173	$ (45)	$ 427
Discontinued operations	—	—	—	—
	$ 299	$ 173	$ (45)	$ 427
Three Months Ended March 31, 2015				
Continuing operations	$ 73	$ 3	$ (15)	$ 61
Discontinued operations	10	(3)	—	7
	$ 83	$ —	$ (15)	$ 68

For the three months ended March 31, 2016 and 2015, we recorded costs of $173 million and $3 million, respectively, in continuing operations in connection with significant legal proceedings and governmental reviews. During the three months ended March 31, 2015, we reduced a previously established reserve for a legal matter in discontinued operations by approximately $3 million based on updated claims information.

NOTE 11. REDEEMABLE NONCONTROLLING INTERESTS IN EQUITY OF CONSOLIDATED SUBSIDIARIES

The following table shows the changes in redeemable noncontrolling interests in equity of consolidated subsidiaries during the three months ended March 31, 2016 and 2015:

	Three Months Ended March 31,	
	2016	2015
Balances at beginning of period	$ 2,266	$ 401
Net income	80	21
Distributions paid to noncontrolling interests	(34)	(1)
Contributions from noncontrolling interests	6	1
Purchases and sales of businesses and noncontrolling interests, net	63	(214)
Balances at end of period	$ 2,381	$ 208

NOTE 12. INCOME TAXES

During the three months ended March 31, 2016, we recorded income tax expense of $67 million in continuing operations on pre-tax earnings of $105 million. The recorded income tax differs from taxes calculated at the statutory rate primarily due to state income tax expense of approximately $13 million, tax benefits of $21 million related to net income attributable to noncontrolling partnership interests, which is excluded from the computation of the provision for income taxes, tax expense of $29 million related to nondeductible goodwill, tax benefits of $17 million related to nontaxable gains and related changes in deferred taxes, and tax expense of $26 million related to nondeductible litigation.

During the three months ended March 31, 2016, we decreased our estimated liabilities for uncertain tax positions by $3 million, net of related deferred tax assets. The total amount of unrecognized tax benefits at March 31, 2016 was $37 million, of which $34 million, if recognized, would impact our effective tax rate and income tax expense (benefit) from continuing operations.

Our practice is to recognize interest and penalties related to income tax matters in income tax expense in our consolidated statements of operations. Total accrued interest and penalties on unrecognized tax benefits at March 31, 2016 were $5 million, all of which related to continuing operations.

At March 31, 2016, approximately $6 million of unrecognized federal and state tax benefits, as well as reserves for interest and penalties, may decrease in the next 12 months as a result of the settlement of audits, the filing of amended tax returns or the expiration of statutes of limitations.

NOTE 13. EARNINGS (LOSS) PER COMMON SHARE

The table below is a reconciliation of the numerators and denominators of our basic and diluted earnings (loss) per common share calculations for our continuing operations for three months ended March 31, 2016 and 2015. Net income available (loss attributable) to our common shareholders is expressed in millions and weighted average shares are expressed in thousands.

	Net Income Available (Loss Attributable) to Common Shareholders (Numerator)	Weighted Average Shares (Denominator)	Per-Share Amount
Three Months Ended March 31, 2016			
Net loss attributable to Tenet Healthcare Corporation common shareholders for basic loss per share	$ (55)	98,768	$ (0.56)
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	—	—
Net loss attributable to Tenet Healthcare Corporation common shareholders for diluted loss per share	**$ (55)**	**98,768**	**$ (0.56)**
Three Months Ended March 31, 2015			
Net income available to Tenet Healthcare Corporation common shareholders for basic earnings per share	$ 46	98,699	$ 0.47
Effect of dilutive stock options, restricted stock units and deferred compensation units	—	2,173	(0.01)
Net income available to Tenet Healthcare Corporation common shareholders for diluted earnings per share	**$ 46**	**100,872**	**$ 0.46**

All potentially dilutive securities were excluded from the calculation of diluted loss per share for the three months ended March 31, 2016 because we did not report income from continuing operations available to common shareholders in that period. In circumstances where we do not have income from continuing operations available to common shareholders, the effect of stock options and other potentially dilutive securities is anti-dilutive, that is, a loss from continuing operations attributable to common shareholders has the effect of making the diluted loss per share less than the basic loss per share. Had we generated income from continuing operations available to common shareholders in the three months ended March 31, 2016, the effect (in thousands) of employee stock options, restricted stock units and deferred compensation units on the diluted shares calculation would have been an increase of 1,567 shares.

NOTE 14. FAIR VALUE MEASUREMENTS

Our financial assets and liabilities recorded at fair value on a recurring basis primarily relate to investments in available-for-sale securities held by our captive insurance subsidiaries. The following tables present information about our assets and liabilities that are measured at fair value on a recurring basis. The following tables also indicate the fair value hierarchy of the valuation techniques we utilized to determine such fair values. In general, fair values determined by Level 1 inputs utilize quoted prices (unadjusted) in active markets for identical assets or liabilities. We consider a security that trades at least weekly to have an active market. Fair values determined by Level 2 inputs utilize data points that are observable, such as quoted prices, interest rates and yield curves. Fair values determined by Level 3 inputs are unobservable data points for the asset or liability, and include situations where there is little, if any, market activity for the asset or liability.

Investments	March 31, 2016	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable debt securities — noncurrent	$ 60	$ 25	$ 35	$ —
	$ 60	$ 25	$ 35	$ —

Investments	December 31, 2015	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Marketable debt securities — noncurrent	$ 59	$ 24	$ 35	$ —
	$ 59	$ 24	$ 35	$ —

The fair value of our long-term debt (except for borrowings under the Credit Agreement) is based on quoted market prices (Level 1). The inputs used to establish the fair value of the borrowings outstanding under the Credit Agreement are considered to be Level 2 inputs, which include inputs other than quoted prices included in Level 1 that are observable, either directly or indirectly. At March 31, 2016 and December 31, 2015, the estimated fair value of our long-term debt was approximately 99.1% and 96.2%, respectively, of the carrying value of the debt.

NOTE 15. ACQUISITIONS

Preliminary purchase price allocations (representing the fair value of the consideration conveyed) for all acquisitions made during the three months ended March 31, 2016 are as follows:

Current assets	$ 30
Property and equipment	24
Other intangible assets	5
Goodwill	114
Other long-term assets	6
Current liabilities	(9)
Other long-term liabilities	(13)
Redeemable noncontrolling interests in equity of consolidated subsidiaries	(62)
Noncontrolling interests	(37)
Cash paid, net of cash acquired	(29)
Gains on consolidations	**$ 29**

The goodwill generated from these transactions, the majority of which will not be deductible for income tax purposes, was recorded in our Ambulatory Care segment and can be attributed to the benefits that we expect to realize from operating efficiencies and growth strategies. Approximately $5 million in transaction costs related to prospective and closed acquisitions were expensed during the three months ended March 31, 2016, and are included in impairment and restructuring charges, and acquisition-related costs in the accompanying Condensed Consolidated Statement of Operations.

We are required to allocate the purchase prices of acquired businesses to assets acquired or liabilities assumed and, if applicable, noncontrolling interests based on their fair values. The excess of the purchase price allocation over those fair values is recorded as goodwill. We are in process of finalizing the purchase price allocations, including valuations of the acquired property and equipment, other intangible assets, investments in affiliates and noncontrolling interests for our 2016 and 2015 acquisitions; therefore, those purchase price allocations are subject to adjustment once the valuations are completed.

During the three months ended March 31, 2016, we recognized gains totaling $29 million, associated with stepping up our ownership interests in previously held equity investments, which we began consolidating after we acquired controlling interests.

Pro Forma Information – Unaudited

The following table provides 2016 actual results compared to 2015 pro forma information for Tenet as if the USPI joint venture and Aspen acquisition had occurred at the beginning of the year ended December 31, 2015.

	Three Months Ended March 31,	
	2016	2015
Net operating revenues	$ 5,044	$ 4,629
Equity in earnings of unconsolidated affiliates	$ 24	$ 25
Net income available (loss attributable) to common shareholders	$ (59)	$ 28
Earnings (loss) per share available (attributable) to common shareholders	$ (0.60)	$ 0.28

NOTE 16. SEGMENT INFORMATION

Our business consists of our Hospital Operations and other segment, our Ambulatory Care segment and our Conifer segment. The factors for determining the reportable segments include the manner in which management evaluates operating performance combined with the nature of the individual business activities.

Our core business is Hospital Operations and other, which is focused on operating acute care hospitals, ancillary outpatient facilities, freestanding emergency departments, physician practices and health plans. We also own various related healthcare businesses. At March 31, 2016, our subsidiaries operated 84 hospitals, with a total of 21,529 licensed beds, primarily serving urban and suburban communities in 13 states, and six health plans, as well as hospital-based outpatient centers, freestanding emergency departments and freestanding urgent care centers.

Our Ambulatory Care segment is comprised of the operations of our USPI joint venture and our nine Aspen facilities in the United Kingdom. At March 31, 2016, our USPI joint venture had interests in 250 ambulatory surgery centers, 35 urgent care centers, 21 imaging centers and 20 short-stay surgical hospitals in 28 states.

Our Conifer segment provides healthcare business process services in the areas of revenue cycle management and technology-enabled performance improvement and health management solutions to health systems, as well as individual hospitals, physician practices, self-insured organizations and health plans. At March 31, 2016, Conifer provided services to more than 800 Tenet and non-Tenet hospitals and other clients nationwide. Our Conifer subsidiary and our Hospital Operations and other segment entered into formal agreements documenting terms and conditions of various services provided by Conifer to Tenet hospitals, as well as certain administrative services provided by our Hospital Operations and other segment to Conifer. The services provided by both parties under these agreements are charged to the other party based on estimated third-party pricing terms.

The following tables include amounts for each of our reportable segments and the reconciling items necessary to agree to amounts reported in the accompanying Condensed Consolidated Balance Sheets and Condensed Consolidated Statements of Operations:

	March 31, 2016	December 31, 2015
Assets:		
Hospital Operations and other	$ 17,131	$ 17,353
Ambulatory Care	5,467	5,159
Conifer	1,168	1,170
Total	**$ 23,766**	**$ 23,682**

	Three Months Ended March 31,	
	2016	2015
Capital expenditures:		
Hospital Operations and other	$ 191	$ 176
Ambulatory Care	12	4
Conifer	5	4
Total	**$ 208**	**$ 184**
Net operating revenues:		
Hospital Operations and other	$ 4,397	$ 4,151
Ambulatory Care	429	91
Conifer		
Tenet	167	160
Other customers	218	182
Total Conifer revenues	385	342
Intercompany eliminations	(167)	(160)
Total	**$ 5,044**	**$ 4,424**
Adjusted EBITDA:		
Hospital Operations and other	$ 414	$ 418
Ambulatory Care	136	29
Conifer	63	82
Total	**$ 613**	**$ 529**
Depreciation and amortization:		
Hospital Operations and other	$ 174	$ 192
Ambulatory Care	25	4
Conifer	13	11
Total	**$ 212**	**$ 207**
Adjusted EBITDA	**$ 613**	**$ 529**
Depreciation and amortization	(212)	(207)
Impairment and restructuring charges, and acquisition-related costs	(28)	(29)
Litigation and investigation costs	(173)	(3)
Interest expense	(243)	(199)
Gains on sales, consolidation and deconsolidation of facilities	147	—
Investment earnings	1	—
Net income from continuing operations before income taxes	**$ 105**	**$ 91**

NOTE 17. RECENT ACCOUNTING STANDARDS

In February 2016, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2016-02, "Leases (Topic 842)" ("ASU 2016-02"), which affects any entity that enters into a lease (as that term is defined in ASU 2016-02), with some specified scope exceptions. The main difference between the guidance in ASU 2016-02 and previous GAAP is the recognition of lease assets and lease liabilities by lessees for those leases classified as operating leases under previous GAAP. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2019.

In March 2016, the FASB issued ASU 2016-09, "Compensation—Stock Compensation (Topic 718) Improvements to Employee Share-Based Payment Accounting" ("ASU 2016-09"), which affects all entities that issue share-based payment awards to their employees. The guidance in ASU 2016-09 simplifies several aspects of the accounting for share-based payment transactions, including the income tax consequences, classification of awards as either equity or liabilities, and classification on the statement of cash flows. Some of the areas of simplification apply

only to nonpublic entities. We are currently evaluating the potential impact of this guidance, which will be effective for us beginning in 2017.

NOTE 18. SUBSEQUENT EVENTS

As previously disclosed, as part of the formation of our USPI joint venture in 2015, we entered into a put/call agreement (the "Put/Call Agreement") with respect to the equity interests in the joint venture held by our joint venture partners. Each year starting in 2016, our joint venture partners must put to us at least 12.5%, and may put up to 25%, of the equity held by them in the joint venture immediately after the closing. In January 2016, Welsh, Carson, Anderson & Stowe, on behalf of our joint venture partners, delivered a put notice for the minimum number of shares they are required to put to us in 2016 according to the Put/Call Agreement. In April 2016, we paid approximately $127 million to purchase these shares, which increased our ownership interest in the USPI joint venture to approximately 56.3%.

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

INTRODUCTION TO MANAGEMENT'S DISCUSSION AND ANALYSIS

The purpose of this section, Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), is to provide a narrative explanation of our financial statements that enables investors to better understand our business, to enhance our overall financial disclosures, to provide the context within which our financial information may be analyzed, and to provide information about the quality of, and potential variability of, our financial condition, results of operations and cash flows. Our core business is our Hospital Operations and other segment, which is focused on operating acute care hospitals, ancillary outpatient facilities, freestanding emergency departments, physician practices and health plans. Our Ambulatory Care segment is comprised of the operations of our USPI Holding Company, Inc. ("USPI joint venture"), in which we acquired a majority interest on June 16, 2015, and European Surgical Partners Limited ("Aspen") facilities, which we also acquired on June 16, 2015. At March 31, 2016, our USPI joint venture had interests in 250 ambulatory surgery centers, 35 urgent care centers, 21 imaging centers and 20 short-stay surgical hospitals in 28 states, and Aspen operated nine private hospitals and clinics in the United Kingdom. Our Conifer segment provides healthcare business process services in the areas of revenue cycle management and technology-enabled performance improvement and health management solutions to health systems, as well as individual hospitals, physician practices, self-insured organizations and health plans, through our Conifer Holdings, Inc. ("Conifer") subsidiary. MD&A, which should be read in conjunction with the accompanying Condensed Consolidated Financial Statements, includes the following sections:

- Management Overview
- Forward-Looking Statements
- Sources of Revenue
- Results of Operations
- Liquidity and Capital Resources
- Off-Balance Sheet Arrangements
- Critical Accounting Estimates

Unless otherwise indicated, all financial and statistical information included in MD&A relates to our continuing operations, with dollar amounts expressed in millions (except per share, per admission, per adjusted admission, per patient day, per adjusted patient day, per visit and per case amounts). Continuing operations information includes the results of (i) our same 72 hospitals and six health plans operated throughout the three months ended March 31, 2016 and 2015, (ii) our USPI joint venture, in which we acquired a majority interest on June 16, 2015, (iii) Aspen, which we also acquired on June 16, 2015, (iv) Hi-Desert Medical Center, which we began operating on July 15, 2015, (v) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (vi) Saint Louis University Hospital, which we divested on August 31, 2015, (vii) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, (viii) DMC Surgery Hospital, which we closed in October 2015, (ix) Central Carolina Hospital and Frye Regional Medical Center, which we divested effective January 1, 2016, and (x) Centennial Medical Center, Doctors Hospital at White Rock Lake, Lake Pointe Medical Center, and Texas Regional Medical Center at Sunnyvale (collectively, "our North Texas hospitals"), in which we divested a controlling interest effective January 1, 2016, but continue to operate, in each case only for the period from acquisition, or commencement of operations of the facility, as the case may be, to March 31, 2016 and 2015 or to the date of divestiture, as applicable. Continuing operations information excludes the results of our hospitals and other businesses that have been classified as discontinued operations for accounting purposes. Certain previously reported information, primarily related to our freestanding ambulatory surgery and imaging center assets that were contributed to the USPI joint venture, has been reclassified to conform to the current-year presentation.

These outpatient facilities were formerly part of our Hospital Operations and other segment, but are now reported as part of our new Ambulatory Care segment.

MANAGEMENT OVERVIEW

RECENT DEVELOPMENTS

USPI Put Notice—In January 2016, Welsh, Carson, Anderson & Stowe, on behalf of our USPI joint venture partners, delivered a put notice for the minimum number of shares they are required to put to us in 2016 according to a previously disclosed put/call agreement. In April 2016, we paid approximately $127 million to purchase shares subject to the put notice, which increased our ownership interest in the USPI joint venture to approximately 56.3%.

Sale of Georgia Hospitals—On March 31, 2016, we completed the sale of our Atlanta-area hospitals – Atlanta Medical Center and its South Campus, North Fulton Hospital, Spalding Regional Hospital and Sylvan Grove Hospital – as well as 26 physician clinics. As a result of this transaction, we recorded a pre-tax gain on sale of approximately $113 million in the three months ended March 31, 2016.

STRATEGIES AND TRENDS

We are committed to providing the communities we serve with high quality, cost-effective healthcare while growing our business, increasing our profitability and creating long-term value for our shareholders. We believe that our success in increasing our profitability depends in part on our success in executing the strategies and managing the trends discussed below.

Core Business Strategy—We are focused on providing high quality care to patients through our hospitals and outpatient centers, and offering an array of business process solutions primarily to healthcare providers through Conifer. With respect to our hospitals, ambulatory care centers and other outpatient businesses, we seek to offer superior quality and patient services to meet community needs, to make capital and other investments in our facilities and technology, to recruit and retain physicians, and to negotiate competitive contracts with managed care and other private payers. With respect to business process services, we provide comprehensive operational management for revenue cycle functions, including patient access, health information management, revenue integrity and patient financial services. We also offer communication and engagement solutions to optimize the relationship between providers and patients. In addition, Conifer operates a management services business that supports value-based performance through clinical integration, financial risk management and population health management.

Commitment to Quality—We are continuing to make significant investments in equipment, technology, education and operational strategies designed to improve clinical quality at all of our facilities. In addition, we continually collaborate with physicians to implement the most current evidence-based medicine techniques to improve the way we provide care, while using labor management tools and supply chain initiatives to reduce variable costs. We believe the use of these practices will promote the most effective and efficient utilization of resources and result in shorter lengths of stay and reductions in readmissions for hospitalized patients.

Development Strategies—We remain focused on opportunities to increase our hospital and outpatient revenues, and to expand our Conifer services business, through organic growth, corporate development activities and strategic partnerships.

From time to time, we build new facilities, make acquisitions of healthcare assets and companies, and enter into joint venture arrangements or affiliations with healthcare businesses in markets where we believe our operating strategies can improve performance and create shareholder value. Effective January 1, 2016, we formed two joint ventures with Baylor Scott & White Health ("BSW") involving the ownership and operation of our North Texas hospitals – which were

operated by certain of our subsidiaries – and Baylor Medical Center at Garland – which was operated by BSW. The joint ventures will focus on delivering integrated, value-based care primarily to select communities in Rockwall, Collin and Dallas counties. BSW holds a majority ownership interest in the joint ventures.

Historically, our outpatient services have generated significantly higher margins for us than inpatient services. During the three months ended March 31, 2016, we derived approximately 40% of our net patient revenues from outpatient services. By expanding our outpatient business, we expect to increase our profitability over time. The surgical facilities in our USPI joint venture specialize in non-emergency surgical cases. Due in part to advancements in medical technology, and due to the lower cost structure and greater efficiencies that are attainable in a specialized outpatient site, we believe the volume and complexity of surgical cases performed in an outpatient setting will continue to steadily increase. In addition, we have continued growing our imaging and urgent care businesses through our USPI joint venture's acquisitions, including the December 31, 2015 acquisition of CareSpot Express Healthcare, which added 35 urgent care centers in Florida and Tennessee to our USPI joint venture's portfolio of outpatient centers. These acquisitions reflect our broader strategies to (1) offer more services to patients, (2) broaden the capabilities we offer to health system and physician partners to include other outpatient settings beyond the core ambulatory care business, and (3) expand into faster-growing, less capital intensive, higher-margin businesses. Furthermore, we continually evaluate joint venture opportunities with other healthcare providers in our markets to maximize effectiveness, reduce costs and build clinically integrated networks that provide quality services across the care continuum.

We intend to continue to market and expand Conifer's revenue cycle management, patient communications and engagement services, and management services businesses. Conifer provides services to more than 800 Tenet and non-Tenet hospital and other clients nationwide. Historically, this business has generated high margins and improved our overall results of operations. Conifer's service offerings have also expanded to support value-based performance through clinical integration, financial risk management and population health management, which are integral parts of the healthcare industry's movement toward accountable care organizations ("ACOs") and similar risk-based or capitated contract models. In addition to hospitals and independent physician associations, clients for these services include health plans, self-insured employers, government agencies and other entities. We also remain focused on developing, acquiring or entering into joint venture arrangements to establish new capabilities at Conifer.

General Economic Conditions—We believe that slow wage growth in some of the markets our hospitals serve and other adverse economic conditions have had a negative impact on our bad debt expense levels and payer mix. However, as the economy continues to recover, we expect to experience improvements in these metrics relative to recent levels. We believe our volumes were positively impacted in the three months ended March 31, 2016 by incremental market share we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals, and a strengthening economy.

Improving Operating Leverage—We believe targeted capital spending on critical growth opportunities for our hospitals, emphasis on higher-demand clinical service lines (including outpatient lines), focus on expanding our outpatient business, implementation of new payer contracting strategies, and improved quality metrics at our hospitals will improve our patient volumes. We believe our patient volumes have been constrained by the slow pace of the current economic recovery, increased competition, utilization pressure by managed care organizations, the effects of higher patient co-pays and deductibles, and demographic trends. In addition, in several markets, we have formed clinically integrated organizations, which are collaborations with independent physicians and hospitals to develop ongoing clinical initiatives designed to control costs and improve the quality of care delivered to patients. Arrangements like these provide a foundation for negotiating with plans under an ACO structure or other risk-sharing model.

Impact of the Affordable Care Act—We anticipate that we will continue to benefit over time from the provisions of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 ("Affordable Care Act" or "ACA") that have extended insurance coverage through Medicaid or private insurance to a broader segment of the U.S. population. Although we are unable to predict the ultimate net effect of the Affordable Care Act on our future results of operations, and while there have been and will continue to be some reductions in reimbursement rates by governmental payers, we began to receive reimbursement for caring for previously uninsured and underinsured patients in 2014. Through collaborative efforts with local community organizations, we launched a campaign under the banner "Path to Health" to assist our hospitals in educating and enrolling uninsured patients in insurance plans. At

March 31, 2016, we operated hospitals in six of the states (Arizona, California, Illinois, Massachusetts, Michigan and Pennsylvania) that have expanded their Medicaid programs.

Our ability to execute on these strategies and manage these trends is subject to a number of risks and uncertainties that may cause actual results to be materially different from expectations. In addition, it is important that we make steady and measurable progress in successfully integrating acquired businesses and new joint ventures into our business processes, as appropriate. For information about risks and uncertainties that could affect our results of operations, see the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report.

RESULTS OF OPERATIONS—OVERVIEW

The following tables show operating statistics for our continuing operations, which includes the results of (i) our same 72 hospitals and six health plans operated throughout the three months ended March 31, 2016 and 2015, (ii) our USPI joint venture, in which we acquired a majority interest on June 16, 2015, (iii) Aspen, which we also acquired on June 16, 2015, (iv) Hi-Desert Medical Center, which we began operating on July 15, 2015, (v) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (vi) Saint Louis University Hospital, which we divested on August 31, 2015, (vii) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, (viii) DMC Surgery Hospital, which we closed in October 2015, (ix) Central Carolina Hospital and Frye Regional Medical Center, which we divested effective January 1, 2016, and (x) our North Texas hospitals, in which we divested a controlling interest effective January 1, 2016, but continue to operate, in each case only for the period from acquisition, or commencement of operations of the facility, as the case may be, to March 31, 2016 and 2015 or to the date of divestiture, as applicable. We believe this information is useful to investors because it reflects our current portfolio of operations and the recent trends we are experiencing with respect to volumes, revenues and expenses.

	Continuing Operations Three Months Ended March 31,		
Selected Operating Statistics	2016	2015	Increase (Decrease)
Hospital Operations and other			
Number of hospitals (at end of period)	80	80	— [1]
Total admissions	211,799	208,333	1.7 %
Adjusted patient admissions[2]	362,819	349,097	3.9 %
Paying admissions (excludes charity and uninsured)	201,436	197,383	2.1 %
Charity and uninsured admissions	10,363	10,950	(5.4)%
Emergency department visits	925,972	875,077	5.8 %
Total surgeries	132,584	121,403	9.2 %
Patient days — total	1,010,514	975,912	3.5 %
Adjusted patient days[2]	1,714,369	1,618,516	5.9 %
Average length of stay (days)	4.77	4.68	1.9 %
Average licensed beds	21,524	20,823	3.4 %
Utilization of licensed beds[3]	51.6 %	52.1 %	(0.5)%[1]
Total visits	2,146,618	1,994,573	7.6 %
Paying visits (excludes charity and uninsured)	1,984,515	1,837,376	8.0 %
Charity and uninsured visits	162,103	157,197	3.1 %
Ambulatory Care			
Total consolidated facilities (at end of period)	211	64	147 [1]
Total cases	444,239	150,771	194.6 %

(1) The change is the difference between the 2016 and 2015 amounts shown.
(2) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services provided by facilities in our Hospital Operations and other segment by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.
(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

Total admissions increased by 3,466, or 1.7%, in the three months ended March 31, 2016 compared to the three months ended March 31, 2015. Total surgeries increased by 9.2% in the three months ended March 31, 2016 compared

to the same period in 2015. Our emergency department visits increased 5.8% in the three months ended March 31, 2016 compared to the same period in the prior year. Our volumes were positively impacted by acquisitions, as well as, we believe, incremental market share we generated through improved physician alignment and service line expansion, insurance coverage for a greater number of individuals, and a strengthening economy.

	Continuing Operations Three Months Ended March 31,		
Revenues	2016	2015	Increase (Decrease)
Net operating revenues before provision for doubtful accounts	$ 5,420	$ 4,787	13.2 %
Hospital Operations and other			
Revenues from charity and the uninsured	$ 223	$ 264	(15.5)%
Net inpatient revenues[1]	$ 2,781	$ 2,691	3.3 %
Net outpatient revenues[1]	$ 1,514	$ 1,412	7.2 %
Ambulatory Care revenues	$ 429	$ 91	371.4 %
Conifer revenues	$ 385	$ 342	12.6 %

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $78 million and $106 million for the three months ended March 31, 2016 and 2015, respectively. Net outpatient revenues include self-pay revenues of $145 million and $158 million for the three months ended March 31, 2016 and 2015, respectively.

Net operating revenues before provision for doubtful accounts increased by $633 million, or 13.2%, in the three months ended March 31, 2016 compared to the same period in 2015, primarily due to acquisitions, increases in our outpatient volumes and improved managed care pricing. Net operating revenues before provision for doubtful accounts in the three months ended March 31, 2016 included $57 million of net revenues from the California provider fee program described in our Annual Report compared to $46 million during the three months ended March 31, 2015.

	Continuing Operations Three Months Ended March 31,		
Provision for Doubtful Accounts	2016	2015	Increase (Decrease)
Provision for doubtful accounts	$ 376	$ 363	3.6 %
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	6.9 %	7.6 %	(0.7)%[1]

(1) The change is the difference between the 2016 and 2015 amounts shown.

Provision for doubtful accounts increased by $13 million, or 3.6%, in the three months ended March 31, 2016 compared to the same period in 2015, and provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 6.9% and 7.6% for the three months ended March 31, 2016 and 2015, respectively. The decrease in the provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts primarily related to the impact of the $41 million decrease in revenues from charity and the uninsured. Our accounts receivable days outstanding ("AR Days") from continuing operations were 50.6 days at March 31, 2016 and 49.5 days at December 31, 2015, within our target of less than 55 days.

Selected Operating Expenses	Continuing Operations Three Months Ended March 31, 2016	2015	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits	$ 2,017	$ 1,908	5.7 %
Supplies	725	670	8.2 %
Other operating expenses	1,073	1,005	6.8 %
Total	$ 3,815	$ 3,583	6.5 %
Ambulatory Care			
Salaries, wages and benefits	$ 146	$ 24	508.3 %
Supplies	86	17	405.9 %
Other operating expenses	86	21	309.5 %
Total	$ 318	$ 62	412.9 %
Conifer			
Salaries, wages and benefits	$ 239	$ 193	23.8 %
Other operating expenses	83	67	23.9 %
Total	$ 322	$ 260	23.8 %
Total			
Salaries, wages and benefits	$ 2,402	$ 2,125	13.0 %
Supplies	811	687	18.0 %
Other operating expenses	1,242	1,093	13.6 %
Total	$ 4,455	$ 3,905	14.1 %
Rent/lease expense[1]			
Hospital Operations and other	$ 61	$ 54	13.0 %
Ambulatory Care	17	7	142.9 %
Conifer	4	3	33.3 %
Total	$ 82	$ 64	28.1 %

(1) Included in other operating expenses.

Selected Operating Expenses per Adjusted Patient Admission	Continuing Operations Three Months Ended March 31, 2016	2015	Increase (Decrease)
Hospital Operations and other			
Salaries, wages and benefits per adjusted patient admission[1]	$ 5,559	$ 5,466	1.7 %
Supplies per adjusted patient admission[1]	1,998	1,919	4.1 %
Other operating expenses per adjusted patient admission[1]	2,980	2,899	2.8 %
Total per adjusted patient admission	$ 10,537	$ 10,284	2.5 %

(1) Adjusted patient admissions represents actual patient admissions adjusted to include outpatient services provided by facilities in our Hospital Operations and other segment by multiplying actual patient admissions by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

Salaries, wages and benefits per adjusted patient admission increased 1.7% in the three months ended March 31, 2016 compared to the same period in 2015. This change is primarily due to annual merit increases for certain of our employees and increased employee health benefits costs in the three months ended March 31, 2016 compared to the three months ended March 31, 2015.

Supplies expense per adjusted patient admission increased 4.1% in the three months ended March 31, 2016 compared to the three months ended March 31, 2015. The change in supplies expense was primarily attributable to higher costs for pharmaceuticals and cardiology supplies, and volume growth in our higher acuity supply-intensive surgical services.

Other operating expenses per adjusted patient admission increased by 2.8% in the three months ended March 31, 2016 compared to the three months ended March 31, 2015. This increase is due to higher contracted services

and medical fees, as well as increased costs associated with our health plans due to an increase in covered lives, which costs were offset by increased health plan revenues. Malpractice expense was $2 million higher in the 2016 period compared to the 2015 period. The 2016 period included an unfavorable adjustment of approximately $12 million due to a 55 basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to an unfavorable adjustment of approximately $5 million as a result of a 26 basis point decrease in the interest rate in the 2015 period.

LIQUIDITY AND CAPITAL RESOURCES OVERVIEW

Cash and cash equivalents were $728 million at March 31, 2016 compared to $356 million at December 31, 2015.

Significant cash flow items in the three months ended March 31, 2016 included:

- Proceeds from sales of facilities and other assets of $573 million;
- Capital expenditures of $208 million;
- Purchases of businesses for $29 million;
- $117 million in aggregate annual 401(k) contributions and $150 million in annual incentive compensation payments, which were accrued as compensation expense in 2015; and
- Interest payments of $132 million.

Net cash provided by operating activities was $147 million in the three months ended March 31, 2016 compared to $57 million net cash used in operating activities in the three months ended March 31, 2015. Key positive and negative factors contributing to the change between the 2016 and 2015 periods include the following:

- Increased income from continuing operations before income taxes of $84 million, excluding net gain on sales of investments, investment earnings (loss), gain (loss) from early extinguishment of debt, interest expense, gains on sales, consolidation and deconsolidation of facilities, litigation and investigation costs, impairment and restructuring charges, and acquisition-related costs, and depreciation and amortization in the three months ended March 31, 2016 compared to the three months ended March 31, 2015;
- $44 million less cash used by the change in accounts receivable, net of provision for doubtful accounts, in the 2016 period;
- Approximately $132 million of additional net cash proceeds in the 2016 period related to supplemental Medicaid programs, primarily in California and Texas;
- Higher aggregate annual 401(k) matching contributions and annual incentive compensation payments of $18 million and $9 million, respectively, in the three months ended March 31, 2016 compared to the three months ended March 31, 2015;
- An increase of $36 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and
- Higher interest payments of $15 million.

Cash flows from operating activities in the first quarter of the calendar year are usually lower than in subsequent quarters of the year, primarily due to the timing of certain working capital requirements during the first quarter, including our annual 401(k) matching contributions and annual incentive compensation payments.

FORWARD-LOOKING STATEMENTS

The information in this report includes "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934, each as amended. All statements, other than statements of historical or present facts, that address activities, events, outcomes, business strategies and other matters that we plan, expect, intend, assume, believe, budget, predict, forecast, project, estimate or anticipate (and other similar expressions) will, should or may occur in the future are forward-looking statements. These forward-looking statements represent management's current expectations, based on currently available information, as to the outcome and timing of future events. They involve known and unknown risks, uncertainties and other factors — many of which we are unable to predict or control — that may cause our actual results, performance or achievements, or healthcare industry results, to be materially different from those expressed or implied by forward-looking statements. Such factors include, but are not limited to, the risks described in the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report.

When considering forward-looking statements, a reader should keep in mind the risk factors and other cautionary statements in our Annual Report and in this report. Should one or more of the risks and uncertainties described in our Annual Report or this report occur, or should underlying assumptions prove incorrect, our actual results and plans could differ materially from those expressed in any forward-looking statement. We specifically disclaim any obligation to update any information contained in a forward-looking statement or any forward-looking statement in its entirety and, therefore, disclaim any resulting liability for potentially related damages.

All forward-looking statements attributable to us are expressly qualified in their entirety by this cautionary statement.

SOURCES OF REVENUE

We earn revenues for patient services from a variety of sources, primarily managed care payers and the federal Medicare program, as well as state Medicaid programs, indemnity-based health insurance companies and self-pay patients (that is, patients who do not have health insurance and are not covered by some other form of third-party arrangement).

The table below shows the sources of net patient revenues before provision for doubtful accounts for our Hospital Operations and other segment, expressed as percentages of net patient revenues before provision for doubtful accounts from all sources:

	Three Months Ended March 31,		
Net Patient Revenues from:	2016	2015	Increase (Decrease)[1]
Medicare	20.0 %	21.9 %	(1.9)%
Medicaid	8.7 %	9.4 %	(0.7)%
Managed care	61.1 %	58.6 %	2.5 %
Indemnity, self-pay and other	10.2 %	10.1 %	0.1 %

(1) The increase (decrease) is the difference between the 2016 and 2015 percentages shown.

Our payer mix on an admissions basis for our Hospital Operations and other segment, expressed as a percentage of total admissions from all sources, is shown below:

	Three Months Ended March 31,		
Admissions from:	2016	2015	Increase (Decrease)[1]
Medicare	27.2 %	28.0 %	(0.8)%
Medicaid	7.3 %	8.2 %	(0.9)%
Managed care	58.1 %	56.3 %	1.8 %
Indemnity, self-pay and other	7.4 %	7.5 %	(0.1)%

(1) The increase (decrease) is the difference between the 2016 and 2015 percentages shown.

GOVERNMENT PROGRAMS

The Centers for Medicare and Medicaid Services ("CMS") is the single largest payer of healthcare services in the United States. Approximately 129 million Americans rely on healthcare benefits through Medicare, Medicaid and the Children's Health Insurance Program ("CHIP"). These three programs are authorized by federal law and directed by CMS, an agency of the U.S. Department of Health and Human Services ("HHS"). Medicare is a federally funded health insurance program primarily for individuals 65 years of age and older, certain younger people with disabilities, and people with end-stage renal disease, and is provided without regard to income or assets. Medicaid is administered by the states and is jointly funded by the federal government and state governments. Medicaid is the nation's main public health insurance program for people with low incomes and is the largest source of health coverage in the United States. The CHIP, which is also administered by the states and jointly funded, provides health coverage to children in families with incomes too high to qualify for Medicaid, but too low to afford private coverage.

Medicare

Medicare offers its beneficiaries different ways to obtain their medical benefits. One option, the Original Medicare Plan (which includes "Part A" and "Part B"), is a fee-for-service payment system. The other option, called Medicare Advantage (sometimes called "Part C" or "MA Plans"), includes health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), private fee-for-service Medicare special needs plans and Medicare medical savings account plans. The major components of our net patient revenues from continuing operations of our Hospital Operations and other segment for services provided to patients enrolled in the Original Medicare Plan for the three months ended March 31, 2016 and 2015 are set forth in the following table:

	Three Months Ended March 31,	
Revenue Descriptions	2016	2015
Medicare severity-adjusted diagnosis-related group — operating	$ 474	$ 457
Medicare severity-adjusted diagnosis-related group — capital	43	42
Outliers	22	18
Outpatient	222	234
Disproportionate share	78	88
Direct Graduate and Indirect Medical Education[1]	64	67
Other[2]	(17)	11
Adjustments for prior-year cost reports and related valuation allowances	13	22
Total Medicare net patient revenues	**$ 899**	**$ 939**

(1) Includes Indirect Medical Education revenues earned by our children's hospitals under the Children's Hospitals Graduate Medical Education Payment Program administered by the Health Resources and Services Administration of HHS.
(2) The other revenue category includes inpatient psychiatric units, inpatient rehabilitation units, one long-term acute care hospital, other revenue adjustments, and adjustments related to the estimates for current-year cost reports and related valuation allowances.

A general description of the types of payments we receive for services provided to patients enrolled in the Original Medicare Plan is provided in our Annual Report. Recent regulatory and legislative updates to the terms of these payment systems and their estimated effect on our revenues can be found under "Regulatory and Legislative Changes" below.

Medicaid

Medicaid programs and the corresponding reimbursement methodologies are administered by the states and vary from state to state and from year to year. Estimated revenues under various state Medicaid programs, including state-funded managed care Medicaid programs, constituted approximately 19.0% and 19.1% of total net patient revenues before provision for doubtful accounts of our continuing general hospitals for the three months ended March 31, 2016 and 2015, respectively. We also receive DSH and other supplemental revenues under various state Medicaid programs. For the three months ended March 31, 2016 and 2015, our total Medicaid revenues attributable to DSH and other supplemental revenues were approximately $227 million and $247 million, respectively.

Several states in which we operate face budgetary challenges that have resulted, and likely will continue to result, in reduced Medicaid funding levels to hospitals and other providers. Because most states must operate with balanced budgets, and the Medicaid program is generally a significant portion of a state's budget, states can be expected to adopt or consider adopting future legislation designed to reduce or not increase their Medicaid expenditures. In addition, some states delay issuing Medicaid payments to providers to manage state expenditures. As an alternative means of funding provider payments, many of the states in which we operate have adopted provider fee programs or received waivers under Section 1115 of the Social Security Act. Under a Medicaid waiver, the federal government waives certain Medicaid requirements, thereby giving states flexibility in the operation of their Medicaid program to allow states to test new approaches and demonstration projects to improve care. Generally the Section 1115 waivers are for a period of five years with an option to extend the waiver for three additional years. Continuing pressure on state budgets and other factors could result in future reductions to Medicaid payments, payment delays or additional taxes on hospitals.

Because we cannot predict what actions the federal government or the states may take under existing legislation and future legislation to address budget gaps, deficits, Medicaid expansion, provider fee programs or Medicaid section 1115 waivers, we are unable to assess the effect that any such legislation might have on our business, but the impact on our future financial position, results of operations or cash flows could be material.

Medicaid-related patient revenues from continuing operations recognized by our Hospital Operations and other segment from Medicaid-related programs in the states in which our hospitals are located, as well as from Medicaid programs in neighboring states, for the three months ended March 31, 2016 and 2015 are set forth in the table below:

	Three Months Ended March 31,			
	2016		2015	
Hospital Location	Medicaid	Managed Medicaid	Medicaid	Managed Medicaid
California	$ 104	$ 103	$ 80	$ 94
Michigan	98	73	85	77
Texas	52	61	94	59
Alabama	27	—	3	—
Florida	22	42	24	41
Georgia	19	9	17	9
Pennsylvania	19	51	17	48
Illinois	18	18	28	10
Massachusetts	8	14	9	12
Arizona	4	55	(2)	26
South Carolina	2	9	4	9
Tennessee	1	8	2	8
North Carolina	—	—	6	1
Missouri	(1)	—	18	4
	$ 373	$ 443	$ 385	$ 398

Regulatory and Legislative Changes

Material updates to the information set forth in our Annual Report about the Medicare and Medicaid payment systems are provided below.

Proposed Payment and Policy Changes to the Medicare Inpatient Prospective Payment Systems

Under Medicare law, CMS is required to annually update certain rules governing the inpatient prospective payment systems ("IPPS"). The updates generally become effective October 1, the beginning of the federal fiscal year. On April 18, 2016, CMS issued Proposed Changes to the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Fiscal Year 2017 Rates ("Proposed IPPS Rule"). The Proposed IPPS Rule includes the following payment and policy changes:

- A market basket increase of 2.8% for Medicare severity-adjusted diagnosis-related group ("MS-DRG") operating payments for hospitals reporting specified quality measure data and that are meaningful users of electronic health record ("EHR") technology (hospitals that do not report specified quality measure data and/or are not meaningful users of EHR technology will receive a reduced market basket increase); CMS is also proposing certain adjustments to the estimated 2.8% market basket increase and the outlier baseline that result in a net operating payment update of 0.65% (before budget neutrality adjustments), including:
  - Market basket index and multifactor productivity reductions required by the ACA of 0.75% and 0.5%, respectively;
  - A documentation and coding recoupment reduction of 1.5% as required by the American Taxpayer Relief Act of 2012;
  - Prospective reversal of the 0.2% reduction related to the two-midnights rule that was first imposed in federal fiscal year ("FFY") 2014;
  - A one-time increase of 0.6% to reverse the 0.2% two-midnights rule reductions imposed in FFYs 2014 through 2016; and
  - A 0.2% reduction in the FFY 2016 estimated outlier baseline of 5.3% to ensure that FFY 2017 outlier payments do not exceed 5.1% of total IPPS payments.
- Updates to the factors used to determine the amount and distribution of Medicare uncompensated care disproportionate share ("UC-DSH") payments;
- A 1.73% net increase in the capital federal MS-DRG rate;
- An increase in the cost outlier threshold from $22,544 to $23,681; and
- A proposed three-year transition beginning in FFY 2018 to use uncompensated care to determine the distribution of the UC-DSH payments.

CMS projects that the combined impact of the payment and policy changes in the Proposed IPPS Rule will yield an average 0.6% increase in operating MS-DRG payments for hospitals in large urban areas (populations over one million) in FFY 2016. The proposed payment and policy changes affecting operating MS-DRG payments and other proposals, notably those affecting Medicare UC-DSH payments, would result in an estimated 0.1% increase in our annual IPPS payments, which yields an estimated decrease of approximately $2 million in our annual Medicare IPPS payments. Because of the uncertainty regarding factors that may influence our future IPPS payments by individual hospital, including legislative action, admission volumes, length of stay and case mix, as well as potential changes to the proposed rule, we cannot provide any assurances regarding our estimate of the impact of the proposed changes.

PRIVATE INSURANCE

Managed Care

We currently have thousands of managed care contracts with various HMOs and PPOs. HMOs generally maintain a full-service healthcare delivery network comprised of physician, hospital, pharmacy and ancillary service providers that HMO members must access through an assigned "primary care" physician. The member's care is then managed by his or her primary care physician and other network providers in accordance with the HMO's quality assurance and utilization review guidelines so that appropriate healthcare can be efficiently delivered in the most cost-effective manner. HMOs typically provide reduced benefits or reimbursement (or none at all) to their members who use non-contracted healthcare providers for non-emergency care.

PPOs generally offer limited benefits to members who use non-contracted healthcare providers. PPO members who use contracted healthcare providers receive a preferred benefit, typically in the form of lower co-pays, co-insurance or deductibles. As employers and employees have demanded more choice, managed care plans have developed hybrid products that combine elements of both HMO and PPO plans, including high-deductible healthcare plans that may have limited benefits, but cost the employee less in premiums.

The amount of our managed care net patient revenues during the three months ended March 31, 2016 and 2015 was $2.6 billion and $2.4 billion, respectively. Approximately 62% of our managed care net patient revenues for the three months ended March 31, 2016 was derived from our top ten managed care payers. National payers generated approximately 44% of our total net managed care revenues. The remainder comes from regional or local payers. At both March 31, 2016 and December 31, 2015, approximately 59% of our net accounts receivable for our Hospital Operations and other segment were due from managed care payers.

Revenues under managed care plans are based primarily on payment terms involving predetermined rates per diagnosis, per-diem rates, discounted fee-for-service rates and other similar contractual arrangements. These revenues are also subject to review and possible audit by the payers, which can take several years before they are completely resolved. The payers are billed for patient services on an individual patient basis. An individual patient's bill is subject to adjustment on a patient-by-patient basis in the ordinary course of business by the payers following their review and adjudication of each particular bill. We estimate the discounts for contractual allowances at the individual hospital level utilizing billing data on an individual patient basis. At the end of each month, on an individual hospital basis, we estimate our expected reimbursement for patients of managed care plans based on the applicable contract terms. We believe it is reasonably likely for there to be an approximately 3% increase or decrease in the estimated contractual allowances related to managed care plans. Based on reserves at March 31, 2016, a 3% increase or decrease in the estimated contractual allowance would impact the estimated reserves by approximately $15 million. Some of the factors that can contribute to changes in the contractual allowance estimates include: (1) changes in reimbursement levels for procedures, supplies and drugs when threshold levels are triggered; (2) changes in reimbursement levels when stop-loss or outlier limits are reached; (3) changes in the admission status of a patient due to physician orders subsequent to initial diagnosis or testing; (4) final coding of in-house and discharged-not-final-billed patients that change reimbursement levels; (5) secondary benefits determined after primary insurance payments; and (6) reclassification of patients among insurance plans with different coverage levels. Contractual allowance estimates are periodically reviewed for accuracy by taking into consideration known contract terms, as well as payment history. Although we do not separately accumulate and disclose the aggregate amount of adjustments to the estimated reimbursement for every patient bill, we believe our estimation and review process enables us to identify instances on a timely basis where such estimates need to be revised. We do not believe there were any adjustments to estimates of patient bills that were material to our operating income. In addition, on a corporate-wide basis, we do not record any general provision for adjustments to estimated contractual allowances for managed care plans.

We expect managed care governmental admissions to continue to increase as a percentage of total managed care admissions over the near term. However, the managed Medicare and Medicaid insurance plans typically generate lower yields than commercial managed care plans, which have been experiencing an improved pricing trend. Although we have benefitted from solid year-over-year aggregate managed care pricing improvements for several years, we have seen these improvements moderate recently, and we believe the moderation could continue in future years. In the three months

ended March 31, 2016, our commercial managed care net inpatient revenue per admission from our acute care hospitals was approximately 76% higher than our aggregate yield on a per admission basis from government payers, including managed Medicare and Medicaid insurance plans.

Indemnity

An indemnity-based agreement generally requires the insurer to reimburse an insured patient for healthcare expenses after those expenses have been incurred by the patient, subject to policy conditions and exclusions. Unlike an HMO member, a patient with indemnity insurance is free to control his or her utilization of healthcare and selection of healthcare providers.

SELF-PAY PATIENTS

Self-pay patients are patients who do not qualify for government programs payments, such as Medicare and Medicaid, do not have some form of private insurance and, therefore, are responsible for their own medical bills. A significant number of our self-pay patients are admitted through our hospitals' emergency departments and often require high-acuity treatment that is more costly to provide and, therefore, results in higher billings, which are the least collectible of all accounts.

Self-pay accounts pose significant collectability problems. At both March 31, 2016 and December 31, 2015, approximately 5% of our net accounts receivable for our Hospital Operations and other segment were due from self-pay patients. Further, a significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. We provide revenue cycle management services through our Conifer subsidiary, which is subject to various laws, rules and regulations regarding consumer finance, debt collection and credit reporting activities. For additional information, see Item 1, Business — Regulations Affecting Conifer's Operations, in Part I of our Annual Report.

Conifer has performed systematic analyses to focus our attention on the drivers of bad debt expense for each hospital. While emergency department use is the primary contributor to our provision for doubtful accounts in the aggregate, this is not the case at all hospitals. As a result, we have been increasing our focus on targeted initiatives that concentrate on non-emergency department patients as well. These initiatives are intended to promote process efficiencies in collecting self-pay accounts, as well as co-pay and deductible amounts owed to us by patients with insurance, that we deem highly collectible. We leverage a statistical-based collections model that aligns our operational capacity to maximize our collections performance. We are dedicated to modifying and refining our processes as needed, enhancing our technology and improving staff training throughout the revenue cycle process in an effort to increase collections and reduce accounts receivable.

Over the longer term, several other initiatives we have previously announced should also help address this challenge. For example, our *Compact with Uninsured Patients* ("Compact") is designed to offer managed care-style discounts to certain uninsured patients, which enables us to offer lower rates to those patients who historically had been charged standard gross charges. A significant portion of those charges had previously been written down in our provision for doubtful accounts. Under the Compact, the discount offered to uninsured patients is recognized as a contractual allowance, which reduces net operating revenues at the time the self-pay accounts are recorded. The uninsured patient accounts, net of contractual allowances recorded, are further reduced to their net realizable value through provision for doubtful accounts based on historical collection trends for self-pay accounts and other factors that affect the estimation process.

We also provide charity care to patients who are financially unable to pay for the healthcare services they receive. Most patients who qualify for charity care are charged a per-diem amount for services received, subject to a cap. Except for the per-diem amounts, our policy is not to pursue collection of amounts determined to qualify as charity care; therefore, we do not report these amounts in net operating revenues. Most states include an estimate of the cost of charity care in the determination of a hospital's eligibility for Medicaid DSH payments. These payments are intended to mitigate our cost of uncompensated care, as well as reduced Medicaid funding levels. Generally, our method of measuring the estimated costs uses adjusted self-pay/charity patient days multiplied by selected operating expenses (which include salaries, wages and benefits, supplies and other operating expenses) per adjusted patient day. The adjusted self-pay/charity patient days represents actual self-pay/charity patient days adjusted to include self-pay/charity outpatient

services by multiplying actual self-pay/charity patient days by the sum of gross self-pay/charity inpatient revenues and gross self-pay/charity outpatient revenues and dividing the results by gross self-pay/charity inpatient revenues. The following table shows our estimated costs (based on selected operating expenses) of caring for self-pay patients and charity care patients, as well as revenues attributable to Medicaid DSH and other supplemental revenues we recognized, in the three months ended March 31, 2016 and 2015:

	Three Months Ended March 31,	
	2016	2015
Estimated costs for:		
Self-pay patients	$ 165	$ 164
Charity care patients	$ 44	$ 36
Medicaid DSH and other supplemental revenues	$ 227	$ 247

The expansion of health insurance coverage has resulted in an increase in the number of patients using our facilities who have either health insurance exchange or government healthcare insurance program coverage. However, we continue to have to provide uninsured discounts and charity care due to the failure of states to expand Medicaid coverage and for persons living in the country illegally who are not permitted to enroll in a health insurance exchange or government healthcare insurance program.

RESULTS OF OPERATIONS

The following two tables summarize our consolidated net operating revenues, operating expenses and operating income from continuing operations, both in dollar amounts and as percentages of net operating revenues, for the three months ended March 31, 2016 and 2015:

	Three Months Ended March 31,	
	2016	2015
Net operating revenues:		
General hospitals	$ 4,302	$ 4,117
Other operations	1,118	670
Net operating revenues before provision for doubtful accounts	5,420	4,787
Less provision for doubtful accounts	376	363
Net operating revenues	**5,044**	**4,424**
Equity in earnings of unconsolidated affiliates	**24**	**4**
Operating expenses:		
Salaries, wages and benefits	2,402	2,125
Supplies	811	687
Other operating expenses, net	1,242	1,093
Electronic health record incentives	—	(6)
Depreciation and amortization	212	207
Impairment and restructuring charges, and acquisition-related costs	28	29
Litigation and investigation costs	173	3
Gains on sales, consolidation and deconsolidation of facilities	(147)	—
Operating income	**$ 347**	**$ 290**

	Three Months Ended March 31,	
	2016	2015
Net operating revenues	100.0 %	100.0 %
Equity in earnings of unconsolidated affiliates	0.5 %	0.1 %
Operating expenses:		
Salaries, wages and benefits	47.6 %	48.0 %
Supplies	16.1 %	15.5 %
Other operating expenses, net	24.6 %	24.7 %
Electronic health record incentives	— %	(0.2)%
Depreciation and amortization	4.2 %	4.7 %
Impairment and restructuring charges, and acquisition-related costs	0.6 %	0.7 %
Litigation and investigation costs	3.4 %	0.1 %
Gains on sales, consolidation and deconsolidation of facilities	(2.9)%	— %
Operating income	**6.9 %**	**6.6 %**

Net operating revenues of our general hospitals include inpatient and outpatient revenues for services provided by facilities in our Hospital Operations and other segment, as well as nonpatient revenues (e.g., rental income, management fee revenue, and income from services such as cafeterias, gift shops and parking) and other miscellaneous revenue. Net operating revenues of other operations primarily consist of revenues from (1) physician practices, (2) a long-term acute care hospital, (3) our Ambulatory Care segment, (4) services provided by our Conifer subsidiary to third parties and (5) our health plans. Revenues from our general hospitals represented approximately 79% and 86% of our total net operating revenues before provision for doubtful accounts for the three months ended March 31, 2016 and 2015, respectively.

Net operating revenues from our other operations were $1.118 billion and $670 million in the three months ended March 31, 2016 and 2015, respectively. The increase in net operating revenues from other operations during 2016 primarily relates to revenue cycle services provided by our Conifer subsidiary, as well as revenues from our USPI joint venture and Aspen acquisition, our health plans and physician practices. Equity earnings of unconsolidated affiliates

were $24 million and $4 million for the three months ended March 31, 2016 and 2015, respectively. The increase in equity earnings of unconsolidated affiliates in the 2016 period compared to the 2015 period primarily related to our USPI joint venture.

The following table shows selected operating expenses of our three reportable business segments. Information for our Hospital Operations and other segment is presented on a same-hospital basis, which includes the results of our same 72 hospitals and six health plans operated throughout the three months ended March 31, 2016 and 2015. The results of (i) Hi-Desert Medical Center, which we began operating on July 15, 2015, (ii) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (iii) Saint Louis University Hospital, which we divested on August 31, 2015, (iv) our joint venture with Baptist Health System, Inc., which we formed on October 2, 2015, (v) DMC Surgery Hospital, which we closed in October 2015, (vi) Central Carolina Hospital and Frye Regional Medical Center, which we divested effective January 1, 2016, and (vii) our North Texas hospitals, in which we divested a controlling interest effective January 1, 2016, but continue to operate, are excluded.

	Same-Hospital Continuing Operations Three Months Ended March 31,		
Selected Operating Expenses	2016	2015	Increase (Decrease)
Hospital Operations and other — Same-Hospital			
Salaries, wages and benefits	$ 1,868	$ 1,798	3.9 %
Supplies	660	616	7.1 %
Other operating expenses	999	910	9.8 %
Total	$ 3,527	$ 3,324	6.1 %
Ambulatory Care			
Salaries, wages and benefits	$ 146	$ 24	508.3 %
Supplies	86	17	405.9 %
Other operating expenses	86	21	309.5 %
Total	$ 318	$ 62	412.9 %
Conifer			
Salaries, wages and benefits	$ 239	$ 193	23.8 %
Other operating expenses	83	67	23.9 %
Total	$ 322	$ 260	23.8 %
Rent/lease expense[1]			
Hospital Operations and other	$ 52	$ 48	8.3 %
Ambulatory Care	17	7	142.9 %
Conifer	4	3	33.3 %
Total	$ 73	$ 58	25.9 %

(1) Included in other operating expenses.

RESULTS OF OPERATIONS BY SEGMENT

Our operations are reported under three segments: Hospital Operations and other, which is focused on operating acute care hospitals, ancillary outpatient facilities, freestanding emergency departments, physician practices and health plans; Ambulatory Care, which is comprised of our USPI joint venture's ambulatory surgery centers, urgent care centers, imaging centers and short-stay surgical hospitals, as well as Aspen's hospitals and clinics; and Conifer, which operates revenue cycle management and patient communication and engagement services businesses.

Hospital Operations and Other Segment

The following tables show operating statistics of our continuing operations hospitals on a same-hospital basis, which includes the results of our same 72 hospitals and six health plans operated throughout the three months ended March 31, 2016 and 2015. The results of (i) Hi-Desert Medical Center, which we began operating on July 15, 2015, (ii) our Carondelet Heath Network joint venture, in which we acquired a majority interest on August 31, 2015, (iii) Saint Louis University Hospital, which we divested on August 31, 2015, (iv) our joint venture with Baptist Health

System, Inc., which we formed on October 2, 2015, (v) DMC Surgery Hospital, which we closed in October 2015, (vi) Central Carolina Hospital and Frye Regional Medical Center, which we divested effective January 1, 2016, and (vii) our North Texas hospitals, in which we divested a controlling interest effective January 1, 2016, but continue to operate, are excluded.

	Same-Hospital Continuing Operations Three Months Ended March 31,		
Admissions, Patient Days and Surgeries	**2016**	**2015**	**Increase (Decrease)**
Number of hospitals (at end of period)	72	72	—[1]
Total admissions	193,980	194,143	(0.1)%
Adjusted patient admissions[2]	330,575	323,577	2.2 %
Paying admissions (excludes charity and uninsured)	184,436	184,225	0.1 %
Charity and uninsured admissions	9,544	9,918	(3.8)%
Admissions through emergency department	125,004	124,492	0.4 %
Paying admissions as a percentage of total admissions	95.1 %	94.9 %	0.2 %[1]
Charity and uninsured admissions as a percentage of total admissions	4.9 %	5.1 %	(0.2)%[1]
Emergency department admissions as a percentage of total admissions	64.4 %	64.1 %	0.3 %[1]
Surgeries — inpatient	50,563	50,447	0.2 %
Surgeries — outpatient	66,467	62,949	5.6 %
Total surgeries	117,030	113,396	3.2 %
Patient days — total	911,651	909,116	0.3 %
Adjusted patient days[2]	1,537,812	1,499,932	2.5 %
Average length of stay (days)	4.70	4.68	0.4 %
Licensed beds (at end of period)	19,293	19,393	(0.5)%
Average licensed beds	19,288	19,390	(0.5)%
Utilization of licensed beds[3]	52.5 %	52.1 %	0.4 %[1]

(1) The change is the difference between 2016 and 2015 amounts shown.

(2) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services provided by facilities in our Hospital Operations and other segment by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

(3) Utilization of licensed beds represents patient days divided by number of days in the period divided by average licensed beds.

	Same-Hospital Continuing Operations Three Months Ended March 31,		
Outpatient Visits	**2016**	**2015**	**Increase (Decrease)**
Total visits	1,949,159	1,852,780	5.2 %
Paying visits (excludes charity and uninsured)	1,804,947	1,710,661	5.5 %
Charity and uninsured visits	144,212	142,119	1.5 %
Emergency department visits	726,730	688,242	5.6 %
Surgery visits	66,467	62,949	5.6 %
Paying visits as a percentage of total visits	92.6 %	92.3 %	0.3 %[1]
Charity and uninsured visits as a percentage of total visits	7.4 %	7.7 %	(0.3)%[1]

(1) The change is the difference between 2016 and 2015 amounts shown.

Revenues	Same-Hospital Continuing Operations Three Months Ended March 31, 2016	2015	Increase (Decrease)
Net operating revenues	$ 3,940	$ 3,701	6.5 %
Revenues from charity and the uninsured	$ 223	$ 244	(8.6)%
Net inpatient revenues[1]	$ 2,616	$ 2,501	4.6 %
Net outpatient revenues[1]	$ 1,400	$ 1,289	8.6 %

(1) Net inpatient revenues and net outpatient revenues are components of net operating revenues. Net inpatient revenues include self-pay revenues of $88 million and $100 million for the three months ended March 31, 2016 and 2015, respectively. Net outpatient revenues include self-pay revenues of $135 million and $144 million for the three months ended March 31, 2016 and 2015, respectively.

Revenues on a Per Admission, Per Patient Day and Per Visit Basis	Same-Hospital Continuing Operations Three Months Ended March 31, 2016	2015	Increase (Decrease)
Net inpatient revenue per admission	$ 13,486	$ 12,882	4.7 %
Net inpatient revenue per patient day	$ 2,870	$ 2,751	4.3 %
Net outpatient revenue per visit	$ 718	$ 696	3.2 %
Net patient revenue per adjusted patient admission[1]	$ 12,149	$ 11,713	3.7 %
Net patient revenue per adjusted patient day[1]	$ 2,612	$ 2,527	3.4 %

(1) Adjusted patient admissions/days represents actual patient admissions/days adjusted to include outpatient services provided by facilities in our Hospital Operations and other segment by multiplying actual patient admissions/days by the sum of gross inpatient revenues and outpatient revenues and dividing the results by gross inpatient revenues.

Provision for Doubtful Accounts	Same-Hospital Continuing Operations Three Months Ended March 31, 2016	2015	Increase (Decrease)
Provision for doubtful accounts	$ 351	$ 326	7.7 %
Provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts	8.2 %	8.1 %	0.1 %[1]

(1) The change is the difference between 2016 and 2015 amounts shown.

Selected Operating Expenses	Same-Hospital Continuing Operations Three Months Ended March 31, 2016	2015	Increase (Decrease)
Hospital Operations and other — Same-Hospital			
Salaries, wages and benefits as a percentage of net operating revenues	47.4 %	48.6 %	(1.2)%[1]
Supplies as a percentage of net operating revenues	16.8 %	16.6 %	0.2 %[1]
Other operating expenses as a percentage of net operating revenues	25.4 %	24.6 %	0.8 %[1]

(1) The change is the difference between 2016 and 2015 amounts shown.

Revenues

Same-hospital net operating revenues increased $239 million, or 6.5%, during the three months ended March 31, 2016 compared to the three months ended March 31, 2015. The increase in same-hospital net operating revenues in the 2016 period is primarily due to volume growth in higher acuity inpatient services, higher outpatient volumes, improved terms of our managed care contracts and an increase in our other operations revenues. Same-hospital net inpatient revenues increased $115 million, or 4.6%, and same-hospital adjusted admissions increased 2.2% in the three months ended March 31, 2016 compared to the same period in 2015. We believe our volumes were positively impacted by incremental market share we generated through improved physician alignment and service line expansion,

insurance coverage for a greater number of individuals, and a strengthening economy. Same-hospital net inpatient revenue per admission increased 4.7%, primarily due to the improved terms of our managed care contracts and volume growth in higher acuity service lines, in the three months ended March 31, 2016 compared to the three months ended March 31, 2015. Same-hospital net outpatient revenues increased $111 million, or 8.6%, and same-hospital outpatient visits increased 5.2% in the three months ended March 31, 2016 compared to the same period in 2015. Growth in outpatient revenues and volumes was primarily driven by improved terms of our managed care contracts and increased outpatient volume levels associated with our outpatient development program. Same-hospital net outpatient revenue per visit increased 3.2% in the three months ended March 31, 2016 compared to the three months ended March 31, 2015 primarily due to the improved terms of our managed care contracts.

Provision for Doubtful Accounts

Same-hospital provision for doubtful accounts as a percentage of net operating revenues before provision for doubtful accounts was 8.2% and 8.1% for the three months ended March 31, 2016 and 2015, respectively. The table below shows the consolidated net accounts receivable and allowance for doubtful accounts by payer at March 31, 2016 and December 31, 2015.

	March 31, 2016			December 31, 2015		
	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net	Accounts Receivable Before Allowance for Doubtful Accounts	Allowance for Doubtful Accounts	Net
Medicare	$ 400	$ —	$ 400	$ 360	$ —	$ 360
Medicaid	85	—	85	70	—	70
Net cost report settlements payable and valuation allowances	(47)	—	(47)	(42)	—	(42)
Managed care	1,808	142	1,666	1,715	126	1,589
Self-pay uninsured	459	403	56	509	436	73
Self-pay balance after insurance	228	155	73	208	142	66
Estimated future recoveries from accounts assigned to our Conifer subsidiary	146	—	146	144	—	144
Other payers	434	176	258	442	166	276
Total Hospital Operations and other	3,513	876	2,637	3,406	870	2,536
Ambulatory Care	192	25	167	182	17	165
Total discontinued operations	3	—	3	3	—	3
	$ 3,708	**$ 901**	**$ 2,807**	**$ 3,591**	**$ 887**	**$ 2,704**

A significant portion of our provision for doubtful accounts relates to self-pay patients, as well as co-pays and deductibles owed to us by patients with insurance. Collection of accounts receivable has been a key area of focus, particularly over the past several years. At March 31, 2016, our collection rate on self-pay accounts was approximately 27.3%. Our self-pay collection rate includes payments made by patients, including co-pays and deductibles paid by patients with insurance. Based on our accounts receivable from self-pay patients and co-pays and deductibles owed to us by patients with insurance at March 31, 2016, a 10% decrease or increase in our self-pay collection rate, or approximately 3%, which we believe could be a reasonably likely change, would result in an unfavorable or favorable adjustment to provision for doubtful accounts of approximately $9 million.

Payment pressure from managed care payers also affects our provision for doubtful accounts. We typically experience ongoing managed care payment delays and disputes; however, we continue to work with these payers to obtain adequate and timely reimbursement for our services. Our estimated collection rate from managed care payers was approximately 98.4% at March 31, 2016.

We manage our provision for doubtful accounts using hospital-specific goals and benchmarks such as (1) total cash collections, (2) point-of-service cash collections, (3) AR Days and (4) accounts receivable by aging category. The following tables present the approximate aging by payer of our net accounts receivable from the continuing operations of our Hospital Operations and other segment of $2.684 billion and $2.578 billion at March 31, 2016 and December 31, 2015, respectively, excluding cost report settlements payable and valuation allowances of $47 million and $42 million at March 31, 2016 and December 31, 2015, respectively:

	March 31, 2016				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	91 %	65 %	64 %	26 %	62 %
61-120 days	5 %	17 %	19 %	16 %	13 %
121-180 days	2 %	7 %	9 %	10 %	7 %
Over 180 days	2 %	11 %	8 %	48 %	18 %
Total	**100 %**	**100 %**	**100 %**	**100 %**	**100 %**

	December 31, 2015				
	Medicare	Medicaid	Managed Care	Indemnity, Self-Pay and Other	Total
0-60 days	90 %	65 %	64 %	27 %	62 %
61-120 days	6 %	16 %	16 %	19 %	15 %
121-180 days	2 %	6 %	7 %	11 %	7 %
Over 180 days	2 %	13 %	13 %	43 %	16 %
Total	**100 %**	**100 %**	**100 %**	**100 %**	**100 %**

At March 31, 2016, we had a cumulative total of patient account assignments to our Conifer subsidiary of approximately $2.7 billion related to our continuing operations, but excluding our newly acquired hospitals. These accounts have already been written off and are not included in our receivables or in the allowance for doubtful accounts; however, an estimate of future recoveries from all the accounts assigned to our Conifer subsidiary is determined based on our historical experience and recorded in accounts receivable.

Patient advocates from Conifer's Medicaid Eligibility Program ("MEP") screen patients in the hospital to determine whether those patients meet eligibility requirements for financial assistance programs. They also expedite the process of applying for these government programs. Receivables from patients who are potentially eligible for Medicaid are classified as Medicaid pending, under the MEP, with appropriate contractual allowances recorded. At the present time, our newly acquired facilities are beginning to implement this program. Based on recent trends, approximately 94% of all accounts in the MEP are ultimately approved for benefits under a government program, such as Medicaid. The following table shows the approximate amount of accounts receivable in the MEP still awaiting determination of eligibility under a government program at March 31, 2016 and December 31, 2015 by aging category for the hospitals currently in the program.

	March 31, 2016	December 31, 2015
0-60 days	$ 84	$ 86
61-120 days	14	14
121-180 days	8	7
Over 180 days	16	18
Total	**$ 122**	**$ 125**

Salaries, Wages and Benefits

Same-hospital salaries, wages and benefits as a percentage of net operating revenues decreased 1.2% to 47.4% in the three months ended March 31, 2016 compared to 48.6% for the same period in 2015. While same-hospital net

operating revenues increased 6.5% during the three months ended March 31, 2016 compared to the three months ended March 31, 2015, as previously discussed, same-hospital salaries, wages and benefits increased by only 3.9% in the three months ended March 31, 2016 compared to the 2015 period. This increase in same-hospital salaries, wages and benefits was primarily due to annual merit increases for certain of our employees, and increased employee health benefits costs. Salaries, wages and benefits expense for the three months ended March 31, 2016 and 2015 included stock-based compensation expense of $13 million and $18 million, respectively.

At March 31, 2016, approximately 22% of the employees in our Hospital Operations and other segment were represented by labor unions. There were no unionized employees in our Ambulatory Care segment, and less than 1% of Conifer's employees belong to a union. Unionized employees – primarily registered nurses and service and maintenance workers – are located at 37 of our hospitals, the majority of which are in California, Florida and Michigan. We currently have five expired contracts and are negotiating renewals under extension agreements. We are also negotiating first contracts at five hospitals and one physician practice where employees recently selected union representation. At this time, we are unable to predict the outcome of the negotiations, but increases in salaries, wages and benefits could result from these agreements. Furthermore, there is a possibility that strikes could occur during the negotiation process, which could increase our labor costs and have an adverse effect on our patient admissions and net operating revenues. Future organizing activities by labor unions could increase our level of union representation in 2016.

Supplies

Same-hospital supplies expense as a percentage of net operating revenues increased 0.2% to 16.8% in the three months ended March 31, 2016 compared to 16.6% for the same period in 2015. The increase in supplies expense was primarily attributable to higher costs for pharmaceuticals and cardiology supplies, as well as volume growth in our higher acuity supply-intensive surgical services.

We strive to control supplies expense through product standardization, contract compliance, improved utilization, bulk purchases and operational improvements. The items of current cost reduction focus continue to be cardiac stents and pacemakers, orthopedics and implants, and high-cost pharmaceuticals. We also utilize group-purchasing strategies and supplies-management services in an effort to reduce costs.

Other Operating Expenses, Net

Same-hospital other operating expenses as a percentage of net operating revenues increased 0.8% to 25.4% in the three months ended March 31, 2016 compared to 24.6% for the same period in 2015. The increase in other operating expenses was primarily due to:

- additional medical fees of $15 million;
- increased costs associated with our health plans due to an increase in covered lives of $20 million, which costs were offset by increased health plan revenues; and
- increased costs of contracted services of $37 million.

Same-hospital malpractice expense in the 2016 period included an unfavorable adjustment of approximately $12 million due to a 55 basis point decrease in the interest rate used to estimate the discounted present value of projected future malpractice liabilities compared to an unfavorable adjustment of approximately $5 million as a result of a 26 basis point decrease in the interest rate in the 2015 period.

Ambulatory Care Segment

On June 16, 2015, we completed the transaction that combined our freestanding ambulatory surgery and imaging center assets with the short-stay surgical facility assets of USPI into our new USPI joint venture, and we acquired Aspen, which operates nine private short-stay surgical hospitals and clinics in the United Kingdom, thereby

forming our new Ambulatory Care separate reportable business segment. The results of our USPI joint venture and Aspen are included in the financial and statistical information provided only for the period from acquisition to March 31, 2016.

Our USPI joint venture operates its surgical facilities in partnership with local physicians and, in many of these facilities, a health system partner. We hold an ownership interest in each facility, with each being operated through a separate legal entity. We operate facilities on a day-to-day basis through management services contracts. Our sources of earnings from each facility consist of:

- management services revenues, computed as a percentage of each facility's net revenues (often net of bad debt expense); and
- our share of each facility's net income (loss), which is computed by multiplying the facility's net income (loss) times the percentage of each facility's equity interests owned by us.

Our role as an owner and day-to-day manager provides us with significant influence over the operations of each facility. In many of the facilities our Ambulatory Care segment operates (122 of 335 at March 31, 2016), this influence does not represent control of the facility, so we account for our investment in the facility under the equity method for an unconsolidated affiliate. We control 213 of the facilities we operate and account for these investments as consolidated subsidiaries.

Our net earnings from a facility are the same under either method, but the classification of those earnings differs. For consolidated subsidiaries, our financial statements reflect 100% of the revenues and expenses of the subsidiaries, after the elimination of intercompany amounts. The net profit attributable to owners other than us is classified within "net income attributable to noncontrolling interests."

For unconsolidated affiliates, our consolidated statements of operations reflect our earnings in two line items:

- *equity in earnings of unconsolidated affiliates*—our share of the net income of each facility, which is based on the facility's net income and the percentage of the facility's outstanding equity interests owned by us; and
- *management and administrative services revenues, which is included in our net operating revenues*—income we earn in exchange for managing the day-to-day operations of each facility, usually quantified as a percentage of each facility's net revenues less bad debt expense.

Our Ambulatory Care operating income is driven by the performance of all facilities we operate and by our ownership interests in those facilities, but our individual revenue and expense line items contain only consolidated businesses, which represent 64% of our facilities. This translates to trends in consolidated operating income that often do not correspond with changes in consolidated revenues and expenses.

Three Months Ended March 31, 2016 Compared to Three Months Ended March 31, 2015

The following table summarizes certain consolidated statements of operations items for the periods indicated:

	Three Months Ended March 31,	
Ambulatory Care Results of Operations	**2016**	**2015**
Net operating revenues	$ 429	$ 91
Equity in earnings of unconsolidated affiliates	25	—
Operating expenses, excluding depreciation and amortization	318	62
Depreciation and amortization	25	4
Operating income	**$ 111**	**$ 25**

Our Ambulatory Care net operating revenues increased by $338 million, or 371.4%, for the three months ended March 31, 2016 compared to the three months ended March 31, 2015. The growth in revenues was primarily driven by increases from acquisitions of $334 million.

Salaries, wages and benefits expense increased by $122 million, or 508.3%, for the three months ended March 31, 2016 compared to the three months ended March 31, 2015. This increase was primarily driven by salaries, wages and benefits expense from acquisitions of $120 million.

Supplies expense increased by $69 million, or 405.9%, for the three months ended March 31, 2016 compared to the three months ended March 31, 2015. This increase was primarily driven by supplies expense from acquisitions of $68 million.

Other operating expenses increased by $65 million, or 309.5%, for the three months ended March 31, 2016 compared to the three months ended March 31, 2015. This increase was driven by other operating expenses from acquisitions of $65 million.

Facility Growth

The following table summarizes the changes in our same-facility revenue year-over-year on a pro forma systemwide basis, which includes both consolidated and unconsolidated (equity method) facilities. While we do not record the revenues of our unconsolidated facilities, we believe this information is important in understanding the financial performance of our Ambulatory Care segment because these revenues are the basis for calculating our management services revenues and, together with the expenses of our unconsolidated facilities, are the basis for our equity in earnings of unconsolidated affiliates.

Ambulatory Care Facility Growth	Three Months Ended March 31, 2016
Net revenues	11.0 %
Cases	8.6 %
Net revenue per case	2.2 %

Joint Ventures with Health System Partners

During the three months ended June 30, 2015, we established our new Ambulatory Care segment as a result of our joint venture with USPI and our purchase of Aspen. USPI's business model is to jointly own its facilities with local physicians and not-for-profit health systems. Accordingly, as of March 31, 2016, the majority of facilities in our Ambulatory Care segment are operated in this model.

Ambulatory Care Facilities with Health System Partners	Three Months Ended March 31, 2016
Facilities:	
With a health system partner	179
Without a health system partner	156
Total facilities operated	335
Change from December 31, 2015	
Acquisitions	2
De novo	1
Dispositions/Mergers	(1)
Total increase in number of facilities operated	2

Conifer Segment

Our Conifer subsidiary generated net operating revenues of $385 million and $342 million during the three months ended March 31, 2016 and 2015, respectively, a portion of which was eliminated in consolidation as described in

Note 16 to the Condensed Consolidated Financial Statements. The increase in the revenue from third-party customers, which is not eliminated in consolidation, is primarily due to new clients.

Salaries, wages and benefits expense for Conifer increased $46 million, or 23.8%, in the three months ended March 31, 2016 compared to the three months ended March 31, 2015 due to an increase in employee headcount as a result of the growth in Conifer's business primarily attributable to new clients.

Other operating expenses for Conifer increased $16 million, or 23.9%, in the three months ended March 31, 2016 compared to the three months ended March 31, 2015 due to the growth in Conifer's business primarily attributable to new clients.

Conifer continues to implement revenue cycle initiatives to improve our cash flow. These initiatives are focused on standardizing and improving patient access processes, including pre-registration, registration, verification of eligibility and benefits, liability identification and collection at point-of-service, and financial counseling. These initiatives are intended to reduce denials, improve service levels to patients and increase the quality of accounts that end up in accounts receivable. Although we continue to focus on improving our methodology for evaluating the collectability of our accounts receivable, we may incur future charges if there are unfavorable changes in the trends affecting the net realizable value of our accounts receivable.

Consolidated

Impairment and Restructuring Charges, and Acquisition-Related Costs

During the three months ended March 31, 2016, we recorded impairment and restructuring charges and acquisition-related costs of $28 million, consisting of approximately $2 million to write-down other intangible assets, $10 million of employee severance costs, $1 million of restructuring costs, $1 million of contract and lease termination fees, and $14 million in acquisition-related costs, which include $5 million of transaction costs and $9 million of acquisition integration costs.

During the three months ended March 31, 2015, we recorded impairment and restructuring charges and acquisition-related costs of $29 million, consisting of $6 million of employee severance costs, $3 million of restructuring costs and $20 million in acquisition-related costs, which include $7 million of transaction costs and $13 million in acquisition integration costs.

Litigation and Investigation Costs

Litigation and investigation costs for the three months ended March 31, 2016 and 2015 were $173 million and $3 million, respectively, and were primarily attributable to significant legal proceedings and governmental reviews described in Note 10 to our Condensed Consolidated Financial Statements.

Gains on Sales, Consolidation and Deconsolidation of Facilities

During the three months ended March 31, 2016, we recorded gains on sales, consolidation and deconsolidation of facilities of approximately $147 million, primarily comprised of a $113 million gain from the sale of our Atlanta-area facilities and $29 million of gains related to the consolidation and deconsolidation of certain businesses of our USPI joint venture due to ownership changes.

Interest Expense

Interest expense for the three months ended March 31, 2016 was $243 million compared to $199 million for the same period in 2015, primarily due to increased borrowings related to our recent acquisitions.

Income Tax Expense

During the three months ended March 31, 2016, we recorded income tax expense of $67 million in continuing operations on pre-tax earnings of $105 million. The recorded income tax differs from taxes calculated at the statutory rate primarily due to state income tax expense of approximately $13 million, tax benefits of $21 million related to net income attributable to noncontrolling partnership interests, which is excluded from the computation of the provision for income taxes, tax expense of $29 million related to nondeductible goodwill, tax benefits of $17 million related to nontaxable gains and related changes in deferred taxes, and tax expense of $26 million related to nondeductible litigation, compared to income tax expense of $16 million during the three months ended March 31, 2015.

Net Income Attributable to Noncontrolling Interests

Net income attributable to noncontrolling interests was $93 million for the three months ended March 31, 2016 compared to $29 million for the three months ended March 31, 2015. Net income attributable to noncontrolling interests for the three months ended March 31, 2016 was comprised of $6 million related to our Hospital Operations and other segment, $75 million related to our Ambulatory Care segment and $12 million related to our Conifer segment. Of the portion related to our Ambulatory Care segment, $29 million was related to the minority interest in our USPI joint venture, which included $18 million attributable to $29 million of gains on the consolidation of certain businesses by our USPI joint venture and an associated $7 million favorable income tax adjustment. The portion related to our Conifer segment is due to Catholic Health Initiatives' 23.8% ownership interest in our Conifer Health Solutions, LLC subsidiary.

ADDITIONAL SUPPLEMENTAL NON-GAAP DISCLOSURES

The financial information provided throughout this report, including our Condensed Consolidated Financial Statements and the notes thereto, has been prepared in conformity with accounting principles generally accepted in the United States of America ("GAAP"). However, we use certain non-GAAP financial measures defined below in communications with investors, analysts, rating agencies, banks and others to assist such parties in understanding the impact of various items on our financial statements, some of which are recurring or involve cash payments. We use this information in our analysis of the performance of our business, excluding items we do not consider relevant to the performance of our continuing operations. In addition, from time to time we use these measures to define certain performance targets under our compensation programs.

"Adjusted EBITDA" is a non-GAAP measure that we use in our analysis of the performance of our business, which we define as net income (loss) attributable to our common shareholders before: (1) the cumulative effect of changes in accounting principle, net of tax; (2) net loss (income) attributable to noncontrolling interests; (3) preferred stock dividends; (4) income (loss) from discontinued operations, net of tax; (5) income tax benefit (expense); (6) investment earnings (loss); (7) gain (loss) from early extinguishment of debt; (8) net gain (loss) on sales of investments; (9) interest expense; (10) litigation and investigation benefit (costs), net of insurance recoveries; (11) hurricane insurance recoveries, net of costs; (12) net gains (losses) on sales, consolidation and deconsolidation of facilities; (13) impairment and restructuring charges and acquisition-related costs; and (14) depreciation and amortization. As is the case with all non-GAAP measures, investors should consider the limitations associated with this metric, including the potential lack of comparability of this measure from one company to another, and should recognize that Adjusted EBITDA does not provide a complete measure of our operating performance because it excludes many items that are included in our financial statements. Accordingly, investors are encouraged to use GAAP measures when evaluating our financial performance.

The table below shows the reconciliation of Adjusted EBITDA to net income available (loss attributable) to our common shareholders (the most comparable GAAP term) for the three months ended March 31, 2016 and 2015:

	Three Months Ended March 31,	
	2016	2015
Net income available (loss attributable) to Tenet Healthcare Corporation common shareholders	$ (59)	$ 47
Less: Net income attributable to noncontrolling interests	(93)	(29)
Net income (loss) from discontinued operations, net of tax	(4)	1
Income from continuing operations	38	75
Income tax expense	(67)	(16)
Investment earnings	1	—
Interest expense	(243)	(199)
Operating income	347	290
Litigation and investigation costs	(173)	(3)
Gains on sales, consolidation and deconsolidation of facilities	147	—
Impairment and restructuring charges, and acquisition-related costs	(28)	(29)
Depreciation and amortization	(212)	(207)
Adjusted EBITDA	$ 613	$ 529
Net operating revenues	$ 5,044	$ 4,424
Adjusted EBITDA as % of net operating revenues (Adjusted EBITDA margin)	**12.2 %**	**12.0 %**

LIQUIDITY AND CAPITAL RESOURCES

CASH REQUIREMENTS

There have been no material changes to our obligations to make future cash payments under contracts and under contingent commitments, such as standby letters of credit and minimum revenue guarantees, as disclosed in our Annual Report.

As part of our long-term objective to manage our capital structure, we may from time to time seek to retire, purchase, redeem or refinance some of our outstanding debt or equity securities subject to prevailing market conditions, our liquidity requirements, contractual restrictions and other factors. These actions are part of our strategy to manage our leverage and capital structure over time, which is dependent on our total amount of debt, our available cash balances and our operating results.

At March 31, 2016, using the last 12 months of Adjusted EBITDA, including our USPI joint venture and Aspen's last 12 months of Adjusted EBITDA, our ratio of total long-term debt, net of cash and cash equivalent balances, to Adjusted EBITDA was 5.68x on a consolidated basis. We anticipate this ratio will fluctuate from quarter to quarter based on earnings performance and other factors, including acquisitions that involve the assumption of long-term debt. We intend to manage this ratio by following our business plan, managing our cost structure, possible asset divestitures and through other changes in our capital structure, including, if appropriate, the issuance of equity or convertible securities. Our ability to achieve our leverage and capital structure objectives is subject to numerous risks and uncertainties, many of which are described in the Forward-Looking Statements and Risk Factors sections in Part I of our Annual Report.

Our capital expenditures primarily relate to the expansion and renovation of existing facilities (including amounts to comply with applicable laws and regulations), equipment and information systems additions and replacements (including those required to achieve compliance with the HIT requirements under ARRA), introduction of new medical technologies, design and construction of new buildings, and various other capital improvements, as well as commitments to make capital expenditures in connection with the acquisitions of businesses. Capital expenditures were $208 million and $184 million in the three months ended March 31, 2016 and 2015, respectively. We anticipate that our

capital expenditures for continuing operations for the year ending December 31, 2016 will total approximately $850 million to $900 million, including $133 million that was accrued as a liability at December 31, 2015. Our budgeted 2016 capital expenditures include approximately $5 million to improve disability access at certain of our facilities pursuant to the terms of a negotiated consent decree.

During the three months ended March 31, 2016, we completed the sale of our Atlanta-area hospitals – Atlanta Medical Center and its South Campus, North Fulton Hospital, Spalding Regional Hospital and Sylvan Grove Hospital – as well as 26 physician clinics. As a result of this transaction, we recorded a pre-tax gain on sale of approximately $113 million in the three months ended March 31, 2016.

Interest payments, net of capitalized interest, were $132 million and $117 million in the three months ended March 31, 2016 and 2015, respectively.

Income tax payments, net of tax refunds, were approximately $6 million in the three months ended March 31, 2016, and income tax refunds, net of tax payments, were approximately $1 million in the three months ended March 31, 2015.

SOURCES AND USES OF CASH

Our liquidity for the three months ended March 31, 2016 was primarily derived from net cash provided by operating activities, cash on hand and borrowings under our revolving credit facility. We had approximately $728 million of cash and cash equivalents on hand at March 31, 2016 to fund our operations and capital expenditures, and our borrowing availability under our credit facility was $996 million based on our borrowing base calculation at March 31, 2016.

Our primary source of operating cash is the collection of accounts receivable. As such, our operating cash flow is impacted by levels of cash collections and levels of bad debt due to shifts in payer mix and other factors.

Net cash provided by operating activities was $147 million in the three months ended March 31, 2016 compared to $57 million net cash used in operating activities in the three months ended March 31, 2015. Key positive and negative factors contributing to the change between the 2016 and 2015 periods include the following:

- Increased income from continuing operations before income taxes of $84 million, excluding net gain on sales of investments, investment earnings (loss), gain (loss) from early extinguishment of debt, interest expense, gains on sales, consolidation and deconsolidation of facilities, litigation and investigation costs, impairment and restructuring charges, and acquisition-related costs, and depreciation and amortization in the three months ended March 31, 2016 compared to the three months ended March 31, 2015;

- $44 million less cash used by the change in accounts receivable, net of provision for doubtful accounts, in the 2016 period;

- Approximately $132 million of additional net cash proceeds in the 2016 period related to supplemental Medicaid programs, primarily in California and Texas;

- Higher aggregate annual 401(k) matching contributions and annual incentive compensation payments of $18 million and $9 million, respectively, in the three months ended March 31, 2016 compared to the three months ended March 31, 2015;

- An increase of $36 million in payments on reserves for restructuring charges, acquisition-related costs, and litigation costs and settlements; and

- Higher interest payments of $15 million.

We continue to seek further initiatives to increase the efficiency of our balance sheet by generating incremental cash, including by means of the sale of underutilized or inefficient assets.

Capital expenditures were $208 million and $184 million in the three months ended March 31, 2016 and 2015, respectively.

We record our investments that are available-for-sale at fair market value. As shown in Note 14 to our Condensed Consolidated Financial Statements, the majority of our investments are valued based on quoted market prices or other observable inputs. We have no investments that we expect will be negatively affected by the current economic conditions such that they will materially impact our financial condition, results of operations or cash flows.

DEBT INSTRUMENTS, GUARANTEES AND RELATED COVENANTS

Credit Agreement. On December 4, 2015, we entered into an amendment to our existing senior secured revolving credit facility (as amended, "Credit Agreement") in order to, among other things, extend the scheduled maturity date of the facility, reduce the rates of certain interest and fees payable under the facility and remove certain restrictions with respect to the borrowing base eligibility of certain account receivable. The Credit Agreement provides, subject to borrowing availability, for revolving loans in an aggregate principal amount of up to $1 billion, with a $300 million subfacility for standby letters of credit. The Credit Agreement has a scheduled maturity date of December 4, 2020. We are in compliance with all covenants and conditions in our Credit Agreement. At March 31, 2016, we had no cash borrowings outstanding under the Credit Agreement, and we had approximately $4 million of standby letters of credit outstanding. Based on our eligible receivables, approximately $996 million was available for borrowing under the Credit Agreement at March 31, 2016.

Letter of Credit Facility. We have a letter of credit facility agreement ("LC Facility") that provides for the issuance of standby and documentary letters of credit (including certain letters of credit originally issued under our prior credit agreement, which we transferred to the LC Facility), from time to time, in an aggregate principal amount of up to $180 million (subject to increase to up to $200 million). The LC Facility has a scheduled maturity date of March 7, 2017. We are in compliance with all covenants and conditions in our LC Facility. At March 31, 2016, we had approximately $139 million of standby letters of credit outstanding under the LC Facility.

For information regarding our long-term debt and capital lease obligations, see Note 5 to our Condensed Consolidated Financial Statements.

LIQUIDITY

From time to time, we expect to engage in additional capital markets, bank credit and other financing activities depending on our needs and financing alternatives available at that time. We believe our existing debt agreements provide significant flexibility for future secured or unsecured borrowings.

Our cash on hand fluctuates day-to-day throughout the year based on the timing and levels of routine cash receipts and disbursements, including our book overdrafts, and required cash disbursements, such as interest and income tax payments. These fluctuations result in material intra-quarter net operating and investing uses of cash that has caused, and in the future could cause, us to use our Credit Agreement as a source of liquidity. We believe that existing cash and cash equivalents on hand, availability under our Credit Agreement, anticipated future cash provided by operating activities, and our investments in marketable securities of our captive insurance companies classified as noncurrent investments on our balance sheet should be adequate to meet our current cash needs. These sources of liquidity, in combination with any potential future debt incurrence, should also be adequate to finance planned capital expenditures, payments on the current portion of our long-term debt and other presently known operating needs.

Long-term liquidity for debt service and other purposes will be dependent on the amount of cash provided by operating activities and, subject to favorable market and other conditions, the successful completion of future borrowings or potential refinancings. However, our cash requirements could be materially affected by the use of cash in acquisitions of

businesses, repurchases of securities, the exercise of put rights or other exit options by our joint venture partners, and contractual commitments to fund capital expenditures in, or intercompany borrowings to, businesses we acquire. In addition, liquidity could be adversely affected by a deterioration in our results of operations, including our ability to generate cash from operations, as well as by the various risks and uncertainties discussed in this and other sections of this report, including any costs associated with a significant monetary resolution of the Clinica de la Mama qui tam action and criminal investigation described in Note 10 to our Condensed Consolidated Financial Statements.

We do not rely on commercial paper or other short-term financing arrangements nor do we enter into repurchase agreements or other short-term financing arrangements not otherwise reported in our period-end balance sheets. In addition, we do not have significant exposure to floating interest rates given that substantially all of our current long-term indebtedness has fixed rates of interest.

We continue to aggressively identify and implement further actions to control costs and enhance our operating performance, including cash flow. Among the areas being addressed are capital allocation priorities, volume growth, including the acquisition of outpatient businesses, physician recruitment and alignment strategies, expansion of our Conifer services businesses, managed care payer contracting, procurement efficiencies, cost standardization, bad debt expense reduction initiatives, underperforming hospitals and portfolio optimization, and certain hospital and overhead costs not related to patient care. Although these initiatives may result in improved performance, our performance may remain somewhat below our hospital management company peers because of geographic and other differences in hospital portfolios.

OFF-BALANCE SHEET ARRANGEMENTS

Our consolidated operating results for the three months ended March 31, 2016 and 2015 include $2 million and $20 million, respectively, of net operating revenues and less than $1 million and $1 million, respectively, of operating income generated from hospitals operated by us under operating lease arrangements (one hospital in the three months ended March 31, 2016, which was sold effective March 31, 2016, and two hospitals in the three months ended March 31, 2015). In accordance with GAAP, the applicable buildings and the future lease obligations under these arrangements are not recorded on our consolidated balance sheet.

We have no other off-balance sheet arrangements that may have a current or future material effect on our financial condition, revenues or expenses, results of operations, liquidity, capital expenditures or capital resources, except for $232 million of standby letters of credit outstanding and guarantees at March 31, 2016.

CRITICAL ACCOUNTING ESTIMATES

In preparing our Condensed Consolidated Financial Statements in conformity with GAAP, we must use estimates and assumptions that affect the amounts reported in our Condensed Consolidated Financial Statements and accompanying notes. We regularly evaluate the accounting policies and estimates we use. In general, we base the estimates on historical experience and on assumptions that we believe to be reasonable, given the particular circumstances in which we operate. Actual results may vary from those estimates.

We consider our critical accounting estimates to be those that (1) involve significant judgments and uncertainties, (2) require estimates that are more difficult for management to determine, and (3) may produce materially different outcomes under different conditions or when using different assumptions.

Our critical accounting estimates have not changed from the description provided in our Annual Report.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

The table below presents information about certain of our market-sensitive financial instruments at March 31, 2016. The fair values were determined based on quoted market prices for the same or similar instruments. The

average effective interest rates presented are based on the rate in effect at the reporting date. The effects of unamortized premiums and discounts are excluded from the table.

	Maturity Date, Years Ending December 31,							
	2016	2017	2018	2019	2020	Thereafter	Total	Fair Value
	(Dollars in Millions)							
Fixed rate long-term debt	$ 132	$ 159	$ 1,136	$ 1,679	$ 3,411	$ 7,357	$ 13,874	$ 13,701
Average effective interest rates	5.1 %	6.6 %	6.5 %	5.5 %	6.7 %	7.1 %	6.7 %	
Variable rate long-term debt	$ —	$ —	$ —	$ —	$ 900	$ —	$ 900	$ 933
Average effective interest rates	—	—	—	—	4.1 %	— %	— %	

At March 31, 2016, the potential reduction of annual pretax earnings due to a one percentage point (100 basis point) increase in variable interest rates on long-term debt would be approximately $9 million.

At March 31, 2016, we had long-term, market-sensitive investments held by our captive insurance subsidiaries. Our market risk associated with our investments in debt securities classified as non-current assets is substantially mitigated by the long-term nature and type of the investments in the portfolio.

We have no affiliation with partnerships, trusts or other entities (sometimes referred to as "special-purpose" or "variable-interest" entities) whose purpose is to facilitate off-balance sheet financial transactions or similar arrangements by us. Thus, we have no exposure to the financing, liquidity, market or credit risks associated with such entities.

We do not hold or issue derivative instruments for trading purposes and are not a party to any instruments with leverage or prepayment features.

ITEM 4. CONTROLS AND PROCEDURES

We carried out an evaluation of the effectiveness of the design and operation of our disclosure controls and procedures as defined by Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), as of the end of the period covered by this report with respect to our operations that existed prior to the USPI joint venture and Aspen transactions. The evaluation was performed under the supervision and with the participation of management, including our chief executive officer and chief financial officer. Based upon that evaluation, our chief executive officer and chief financial officer concluded that our disclosure controls and procedures are effective to ensure that material information is recorded, processed, summarized and reported by management on a timely basis in order to comply with our disclosure obligations under the Exchange Act and the SEC rules thereunder.

There were no changes in our internal control over financial reporting during the quarter ended March 31, 2016 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II. OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

Because we provide healthcare services in a highly regulated industry, we have been and expect to continue to be party to various lawsuits, claims and regulatory investigations from time to time. For information regarding material pending legal proceedings in which we are involved, see Note 10 to our Condensed Consolidated Financial Statements, which is incorporated by reference.

ITEM 1A. RISK FACTORS

There have been no material changes to the risk factors discussed in our Annual Report on Form 10-K for the year ended December 31, 2015.

ITEM 6. EXHIBITS

The following exhibits are filed with this report:

(10)	Letter from the Registrant to J. Eric Evans, dated March 22, 2016*
(31)	Rule 13a-14(a)/15d-14(a) Certifications
	(a) Certification of Trevor Fetter, Chief Executive Officer and Chairman of the Board of Directors
	(b) Certification of Daniel J. Cancelmi, Chief Financial Officer
(32)	Section 1350 Certification of Trevor Fetter, Chief Executive Officer and Chairman of the Board of Directors, and Daniel J. Cancelmi, Chief Financial Officer
(101 INS)	XBRL Instance Document
(101 SCH)	XBRL Taxonomy Extension Schema Document
(101 CAL)	XBRL Taxonomy Extension Calculation Linkbase Document
(101 DEF)	XBRL Taxonomy Extension Definition Linkbase Document
(101 LAB)	XBRL Taxonomy Extension Label Linkbase Document
(101 PRE)	XBRL Taxonomy Extension Presentation Linkbase Document

* Management contract or compensatory plan or arrangement

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the Registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

TENET HEALTHCARE CORPORATION
(Registrant)

Date: May 2, 2016

By: /s/ R. SCOTT RAMSEY
R. Scott Ramsey
Vice President and Controller
(Principal Accounting Officer)

Exhibit 10

[Letterhead of Tenet Healthcare Corporation]

March 22, 2016

Jason Eric Evans
[Address Line 1]
[Address Line 2]

Dear Eric:

It has been a pleasure for both me and others here at Tenet to work with you and see your extensive accomplishments since you joined us in 2004. I believe that you would be an outstanding addition to our Executive Leadership Team. I am pleased to offer you the position of President of Hospital Operations at Tenet Healthcare (as an employee of Tenet Employment, Inc.) effective March 22, 2016. This position will report to me and will be located at our headquarters in Dallas, TX.

Compensation and Benefits:

a. Base Compensation: Your base compensation will be an annual exempt rate of $650,000, payable bi-weekly.

b. Health & Welfare Benefits: You will continue to receive all standard health and welfare benefits in accordance with Tenet plans.

c. Annual Incentive Plan: Your target award will be 100% of your base salary, and the actual result is based on our performance vs. targets using the metrics of Tenet's hospital balanced score card. Actual payouts from the AIP plan can vary from 0% to 200% of target.

d. Manager's Time-Off Plan: You will receive four weeks of paid time off and 9 paid holidays during the year under the company's paid time off plan (MTO). In addition, we offer 4 additional discretionary holidays during the winter break before the New Year.

e. Deferred Compensation Plan: The Deferred Compensation Plan (DCP) provides pre-tax compensation deferral options, some of which are eligible for a company match.

f. Long-Term Incentive Award: You will receive a one-time initial grant of restricted stock units valued at $1,000,000 on the last business day of the month you assume the role. Half of this award will vest ratably on each of the first three anniversaries of the grant date. The remaining half of the award will vest on the third anniversary of the grant date based on a three year performance on financial metrics.

g. Executive Severance Plan: The Tenet Executive Severance Plan (ESP) will provide you with the following benefits:

- Two and one-half years of base salary and target annual bonus for a Qualifying Termination as defined in the ESP.
- Three years of base salary and target annual bonus for Qualifying Termination related to a Change of Control

h. Executive Retirement Account (ERA): You will receive an annual credit equal to twenty percent (20%) of your base salary while you are employed in a position that is eligible for benefits under the plan. The credit will occur annually on July 1.

Terms and Conditions of Employment: This offer is contingent upon the execution of the enclosed Confidentiality, Non-Compete and Non-Interference Agreement. Your employment with Tenet will be on an at-will basis, which means that either you or the company may terminate the employment relationship, with or without notice and with or without cause at any time. As used in this letter, the term "cause" shall include, but shall not be limited to, dishonesty, fraud, willful misconduct, self-dealing or violations of the Tenet Standards of Conduct, breach of fiduciary duty (whether or not involving personal profit), failure, neglect or refusal to perform your duties in any material respect, violation of law (except traffic violations or similar minor infractions), violation of Tenet's Human Resources or other Policies, or any material breach of this letter.

Compliance with Tenet Policies, Rules and Regulations: By signing this letter below, you agree to abide by all Tenet Human Resources and other policies, procedures, rules and regulations currently in effect or that may be adopted from time to time, including the Tenet Performance Management policy and the Tenet Standards of Conduct. To the extent that any such policies, rules or regulations, or any benefit plans in which you are a participant, conflict with the terms of this letter, the actual terms of those policies or plans shall control.

Ethics & Compliance: All Tenet employees are required to attend Ethics & Compliance classes within established Tenet policy guidelines, as well as a refresher course every year. Please contact Paul Slavin, or access the company intranet site at www.eTenet.com, for additional information.

Standards of Conduct: As an employee of Tenet, you agree to abide by Tenet's Standards of Conduct, which reflect Tenet's basic values of high-quality, cost-effective health services; honesty, trustworthiness, and reliability in all relationships; leadership in the development of partnership arrangements with providers of health services; good corporate citizenship in the communities where Tenet provides services; pursuit of fiscal responsibility and growth; compliance with all applicable rules, regulations, policies and procedures; and fair treatment of employees.

Conflict Resolution: As a condition of employment, you agree to abide by Tenet's Fair Treatment Process which includes final and binding Arbitration as a resolution to any grievance that results out of your employment or termination of employment with Tenet.

Eric, I would be delighted to have you as part of the team. If you accept this offer, please sign and return the letter to Paul Slavin by March 29, 2016. Please feel free to reach out to me directly or to contact Paul if you have any additional questions.

Sincerely,

/s/ Trevor Fetter

Trevor Fetter
Chairman and CEO

cc: Paul Slavin, VP, Compensation, Benefits & Corporate HR

Acknowledged and accepted:

/s/ J. Eric Evans Date: March 24, 2016
Signature

Exhibit 31(a)

Rule 13a-14(a)/15d-14(a) Certification

I, Trevor Fetter, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Tenet Healthcare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: May 2, 2016

/s/ TREVOR FETTER
Trevor Fetter
Chief Executive Officer and Chairman of the Board of Directors

Exhibit 31(b)

Rule 13a-14(a)/15d-14(a) Certification

I, Daniel J. Cancelmi, certify that:

1. I have reviewed this quarterly report on Form 10-Q of Tenet Healthcare Corporation (the "Registrant");

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the Registrant as of, and for, the periods presented in this report;

4. The Registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the Registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the Registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the Registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the Registrant's internal control over financial reporting that occurred during the Registrant's most recent fiscal quarter (the Registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the Registrant's internal control over financial reporting; and

5. The Registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the Registrant's auditors and the audit committee of the Registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the Registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the Registrant's internal control over financial reporting.

Date: May 2, 2016

/s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer

Exhibit 32

Certifications Pursuant to Section 1350 of Chapter 63 of Title 18 of the United States Code

We, the undersigned Trevor Fetter and Daniel J. Cancelmi, being, respectively, the Chairman, President and Chief Executive Officer and the Chief Financial Officer of Tenet Healthcare Corporation (the "Registrant"), do each hereby certify that (i) the Registrant's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016 (the "Form 10-Q"), to be filed with the Securities and Exchange Commission on the date hereof, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, and (ii) the information contained in the Form 10-Q fairly presents, in all material respects, the financial condition and results of operations of the Registrant and its subsidiaries.

Date: May 2, 2016

/s/ TREVOR FETTER
Trevor Fetter
Chief Executive Officer and Chairman of the Board of Directors

Date: May 2, 2016

/s/ DANIEL J. CANCELMI
Daniel J. Cancelmi
Chief Financial Officer

The foregoing certification is being furnished solely pursuant to 18 U.S.C. §1350; it is not being filed for purposes of Section 18 of the Securities Exchange Act, and is not to be incorporated by reference into any filing of the Registrant, whether made before or after the date hereof, regardless of any general incorporation language in such filing.

Attachment C, Contribution to the Orderly Development Of Health Care

Proof of Publication

Classified Legal Notices

Legals

Legal Notices

NOTICE OF FORECLOSURE SALE
STATE OF TENNESSEE,
SHELBY COUNTY

WHEREAS, Kris James and Gaina James executed a Deed of Trust to Chase Bank USA, N.A., Lender and Kathy Winstead, Trustee(s), which was dated July 31, 2007 and recorded on August 9, 2007 in Instrument No. 07124515, Shelby County, Tennessee Register of Deeds;

WHEREAS, default having been made in the payment of the debt(s) and obligation(s) thereby secured by the said Deed of Trust and the current holder of said Deed of Trust, U.S. Bank Trust, N.A., as Trustee for LSF8 Master Participation Trust, (the "Holder"), appointed the undersigned, Brock & Scott, PLLC, as Substitute Trustee, by an instrument duly recorded in the Office of the Register of Deeds of Shelby County, Tennessee, with all the rights, powers and privileges of the original Trustee named in said Deed of Trust; and

NOW, THEREFORE, notice is hereby given that the entire indebtedness has been declared due and payable as provided in said Deed of Trust by the Holder, and that as agent for the undersigned, Brock & Scott, PLLC, Substitute Trustee, by virtue of the power and authority vested in it, will on **June 7, 2016, at 10:00AM** at the usual and customary location at the Shelby County Courthouse, Memphis, Tennessee, proceed to sell at public outcry to the highest and best bidder for cash, the following described property situated in Shelby County, Tennessee, to wit:

The Following described real estate, situated and being in Memphis, County of Shelby, State of Tennessee:
Lot 143, Section F, John B. Goodwin's Graceland Subdivision, as shown on plat of record in Plat Book 23, Page 15, Register's Office, Shelby County, Tennessee, to which plat reference is hereby made for a more complete legal description.

Property Address: 1351 Favell Drive, Memphis, Tennessee 38116
Parcel ID Number: 079078000001P
Address/Description: 1351 Favell Drive, Memphis, TN 38116.
Current Owner(s): Genna James and Kris James.
Other Interested Parties(s): Internal Revenue Service.
This sale is also subject to the right of redemption by the INTERNAL REVENUE SERVICE, DEPARTMENT OF THE U.S. TREASURY, pursuant to 26 U.S.C. 7425(D)(3) by reason of the following tax lien(s) of record in: Instrument Number 08088447, Serial Number 451661508; Instrument Number 11027575, Serial Number 764923811. Notice of the sale has been given to the Internal Revenue Service in accordance with 26 U.S.C. 7425(b).
The sale of the property described above shall be subject to all matters shown on any recorded plat; any and all liens against said property for unpaid property taxes; any restrictive covenants, easements or set-back lines that may be applicable; any prior liens or encumbrances as well as any priority created by a fixture filing; a deed of trust; and any matter than an accurate survey of the premises might disclose; and
All right and equity of redemption, statutory or otherwise, homestead, and dower are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee. The right is reserved to adjourn the day of the sale to another day, time, and place certain without further publication, upon announcement at the time and place for the sale set forth above.
This office is attempting to collect a debt. Any information obtained will be used for that purpose.
Brock & Scott, PLLC,
Substitute Trustee
c/o Tennessee Foreclosure Department
277 Mallory Station Road
Suite 115
Franklin, TN 37067
PH: 615-550-7697
FX: 615-550-6484
File No.: 15-07166 FC03

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on June 24, 2016 on or about 12:00PM local time, at the Southwest Corner, Adams Avenue Entrance of the Shelby County Courthouse, Memphis, Tennessee, conducted by the Substitute Trustee as identified and set forth hereinbelow, pursuant to Deed of Trust executed by ANTA K NIANG AND BARA NIANG, to JEFFREY F. MCEVOY, Trustee, on January 9, 2007, as Instrument No. 07038052 in the real property records of Shelby County Register's Office, Tennessee.

Owner of Debt: DEUTSCHE BANK NATIONAL TRUST COMPANY, AS TRUSTEE FOR THE REGISTERED HOLDERS OF MORGAN STANLEY ABS CAPITAL I INC. TRUST 2007-HE6 MORTGAGE PASS-THROUGH CERTIFICATES, SERIES 2007-HE6

The following real estate located in Shelby County, Tennessee, will be sold to the highest cash bidder subject to all unpaid taxes, prior liens and encumbrances of record:

LOT 26, PHASE I, STONEBRIAR P.D. AS SHOWN ON PLAT OF RECORD IN PLAT BOOK 214, PAGE 6 IN THE REGISTER'S OFFICE OF SHELBY COUNTY, TENNESSEE, TO WHICH PLAT REFERENCE IS HEREBY MADE FOR A MORE PARTICULAR DESCRIPTION OF SAID PROPERTY.
BEING THE SAME PROPERTY CONVEYED TO GRANTOR, BY WARRANTY DEED RECORDED SIMULTANEOUSLY HEREWITH IN THE REGISTER'S OFFICE OF SHELBY COUNTY, TN.
TAX PARCEL ID: D02-55F-E-00026
PROPERTY KNOWN AS : 7501 EASTERLY LANE, MEMPHIS, TENNESSEE 38125

Tax ID: D02-55F-E-00026

Current Owner(s) of Property: ANTA K NIANG AND BARA NIANG

The street address of the above described property is believed to be 7501 EASTERLY LANE, MEMPHIS, TN 38125, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description referenced herein shall control.

SALE IS SUBJECT TO OCCUPANT(S) RIGHTS IN POSSESSION.

THE RIGHT IS RESERVED TO ADJOURN THE DAY OF THE SALE TO ANOTHER DAY, TIME AND PLACE CERTAIN WITHOUT FURTHER PUBLICATION, UPON ANNOUNCEMENT AT THE TIME AND PLACE FOR THE SALE SET FORTH ABOVE. THE TRUSTEE/SUBSTITUTE TRUSTEE RESERVES THE RIGHT TO RESCIND THE SALE. IF THE SALE IS SET ASIDE FOR ANY REASON, THE PURCHASER AT THE SALE SHALL BE ENTITLED ONLY TO A RETURN OF THE DEPOSIT PAID. THE PURCHASER SHALL HAVE NO FURTHER RECOURSE AGAINST THE GRANTOR, THE GRANTEE, OR THE TRUSTEE.

OTHER INTERESTED PARTIES: MERS AND CITIMORTGAGE, INC.-JUNIOR DOT AND STONEBRIAR HOMEOWNERS ASSOCIATION, INC.

THIS IS AN ATTEMPT TO COLLECT A DEBT AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

If applicable, the notice requirements of T.C.A. 35-5-117 have been met.

All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.

If the U.S. Department of Treasury/IRS, the State of Tennessee Department of Revenue, or the State of Tennessee Department of Labor or Workforce Development are listed as Interested Parties in the advertisement, then the Notice of this foreclosure is being given to them and the Sale will be subject to the applicable governmental entities' right to redeem the property as required by 26 U.S.C. 7425 and T.C.A. §67-1-1433.

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded at any time. If the sale is set aside for any reason, the Purchaser at the sale shall be entitled only to a return of the deposit paid. The Purchaser shall have no further recourse against the Mortgagor, the Mortgagee or the Mortgagee's attorney.

MWZM File No. 16-002028-670

JASON S. MANGRUM, JOHN R. ROAN, or JERRY A. BRIDENBAUGH, Substitute Trustee(s)
PREMIER BUILDING, SUITE 404
5217 MARYLAND WAY
BRENTWOOD, TENNESSEE 37027
PHONE: (615) 238-3630
EMAIL: TNSALES@MWZMLAW.COM

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on June 24, 2016 on or about 12:00PM local time, at the Southwest Corner, Adams Avenue Entrance of the Shelby County Courthouse, Memphis, Tennessee, conducted by the Substitute Trustee as identified and set forth hereinbelow, pursuant to Deed of Trust executed by DERRICK A ROZIER AND STEPHANIE ROZIER, to EQUITY TITLE & ESCROW, Trustee, on October 5, 2004, as Instrument No. 04183864 in the real property records of Shelby County Register's Office, Tennessee and re-filed as Instrument No. 11038822 in the real property records of Shelby County Register's Office, Tennessee.

Owner of Debt: DEUTSCHE BANK NATIONAL TRUST COMPANY, AS TRUSTEE FOR FREMONT HOME LOAN TRUST 2004-A ASSET-BACKED CERTIFICATES, SERIES 2004-A

The following real estate located in Shelby County, Tennessee, will be sold to the highest cash bidder subject to all unpaid taxes, prior liens and encumbrances of record:

LAND SITUATED IN SHELBY COUNTY, TENNESSEE TO WIT:
LOT 240, PHASE IV, ESTANAULA TRAILS SUBDIVISION, AS SHOWN ON PLAT OF RECORD IN PLAT BOOK 197, PAGE 34, IN THE REGISTER'S OFFICE OF SHELBY COUNTY, TENNESSEE, TO WHICH PLAT REFERENCE IS HEREBY MADE FOR A MORE PARTICULAR DESCRIPTION OF SAID PROPERTY.
BEING THE SAME PROPERTY CONVEYED TO GRANTOR, POLO RUN JOINT VENTURE, A TENNESSEE JOINT VENTURE COMPOSED OF UNIQUE PROPERTIES, INC., AND JOHN WORLEY, JR., A BUILDER, INC., HEREIN BY WARRANTY DEED OF RECORD AT INSTRUMENT NUMBER HV 7923, DATED OCTOBER 7, 1998, FILED OCTOBER 19, 1998, IN THE REGISTER'S OFFICE OF SHELBY COUNTY TENNESSEE.
BEING THE SAME PROPERTY CONVEYED TO GRANTOR, COLONIAL HOMES, LLC, HEREIN BY WARRANTY DEED OF RECORD AT INSTRUMENT NUMBER 04031775, DATED FEBRUARY 27, 2004, FILED MARCH 1, 2004, IN THE REGISTER'S OFFICE OF SHELBY COUNTY, TENNESSEE. ALSO BEING THE SAME PROPERTY CONVEYED TO GRANTOR BY WARRANTY DEED OF RECORD BEING RECORDED SIMULTANEOUSLY HEREWITH IN SAID REGISTER'S OFFICE.

Tax ID: D02SA0C00020

Current Owner(s) of Property: DERRICK A ROZIER AND STEPHANIE ROZIER

The street address of the above described property is believed to be 465 ITAWAMBA RD, COLLIERVILLE, TN 38017, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description referenced herein shall control.

SALE IS SUBJECT TO OCCUPANT(S) RIGHTS IN POSSESSION.

THE RIGHT IS RESERVED TO ADJOURN THE DAY OF THE SALE TO ANOTHER DAY, TIME AND PLACE CERTAIN WITHOUT FURTHER PUBLICATION, UPON ANNOUNCEMENT AT THE TIME AND PLACE FOR THE SALE SET FORTH ABOVE. THE TRUSTEE/SUBSTITUTE TRUSTEE RESERVES THE RIGHT TO RESCIND THE SALE. IF THE SALE IS SET ASIDE FOR ANY REASON, THE PURCHASER AT THE SALE SHALL BE ENTITLED ONLY TO A REFUND OF THE DEPOSIT PAID. THE PURCHASER SHALL HAVE NO FURTHER RECOURSE AGAINST THE GRANTOR, THE GRANTEE, OR THE TRUSTEE.

OTHER INTERESTED PARTIES: OCWEN LOAN SERVICING, LLC JUNIOR DOT AND INTERNAL REVENUE SERVICE, GLOBAL IRS OFFICE AND ESTANAULA TRAILS HOMEOWNERS ASSOCIATION, INC AND JUDGMENT IN FAVOR OF ESTANAULA TRAILS HOMEOWNERS ASSOCIATION AND JUDGMENT IN FAVOR OF CRYE-LEIKE REALTORS, INC

THIS IS AN ATTEMPT TO COLLECT A DEBT AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

If applicable, the notice requirements of T.C.A. 35-5-117 have been met.

All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.

If the U.S. Department of Treasury/IRS, the State of Tennessee Department of Revenue, or the State of Tennessee Department of Labor or Workforce Development are listed as Interested Parties in the advertisement, then the Notice of this foreclosure is being given to them and the Sale will be subject to the applicable governmental entities' right to redeem the property as required by 26 U.S.C. 7425 and T.C.A. §67-1-1433.

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded at any time. If the sale is set aside for any reason, the Purchaser at the sale shall be entitled only to a return of the deposit paid. The Purchaser shall have no further recourse against the Mortgagor, the Mortgagee or the Mortgagee's attorney.

MWZM File No. 15-002017-670

JASON S. MANGRUM, JOHN R. ROAN, or JERRY A. BRIDENBAUGH, Substitute Trustee(s)
PREMIER BUILDING, SUITE 404
5217 MARYLAND WAY
BRENTWOOD, TENNESSEE 37027
PHONE: (615) 238-3630
EMAIL: TNSALES@MWZMLAW.COM

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on June 24, 2016 on or about 12:00PM local time, at the Southwest Corner, Adams Avenue Entrance of the Shelby County Courthouse, Memphis, Tennessee, conducted by the Substitute Trustee as identified and set forth hereinbelow, pursuant to Deed of Trust executed by TAMMY E KEOUGH AND MICHAEL KEOUGH, to ARNOLD M. WEISS, Trustee, on August 16, 2005, as Instrument No. 05139998 in the real property records of Shelby County Register's Office, Tennessee.

Owner of Debt: DEUTSCHE BANK NATIONAL TRUST COMPANY, AS TRUSTEE FOR GSAMP TRUST 2005-WMC2

The following real estate located in Shelby County, Tennessee, will be sold to the highest cash bidder subject to all unpaid taxes, prior liens and encumbrances of record:

LAND SITUATED IN SHELBY COUNTY, TENNESSEE.
LOT 81, BARTLETT VILLAGE SUBDIVISION, AS SHOWN ON PLAT OF RECORD IN PLAT BOOK 72, PAGE 34, IN THE REGISTER'S OFFICE OF SHELBY COUNTY, TENNESSEE, TO WHICH PLAT REFERENCE IS HEREBY MADE FOR A MORE PARTICULAR DESCRIPTION OF SAID PROPERTY.

Tax ID: B081S70B0011 39

Current Owner(s) of Property: TAMMY E KEOUGH AND MICHAEL KEOUGH

The street address of the above described property is believed to be 6053 Halstead Street, Memphis, TN 38134, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description referenced herein shall control.

SALE IS SUBJECT TO OCCUPANT(S) RIGHTS IN POSSESSION.

THE RIGHT IS RESERVED TO ADJOURN THE DAY OF THE SALE TO ANOTHER DAY, TIME AND PLACE CERTAIN WITHOUT FURTHER PUBLICATION, UPON ANNOUNCEMENT AT THE TIME AND PLACE FOR THE SALE SET FORTH ABOVE. THE TRUSTEE/SUBSTITUTE TRUSTEE RESERVES THE RIGHT TO RESCIND THE SALE. IF THE SALE IS SET ASIDE FOR ANY REASON, THE PURCHASER AT THE SALE SHALL BE ENTITLED ONLY TO A REFUND OF THE DEPOSIT PAID. THE PURCHASER SHALL HAVE NO FURTHER RECOURSE AGAINST THE GRANTOR, THE GRANTEE, OR THE TRUSTEE.

OTHER INTERESTED PARTIES: OCWEN LOAN SERVICING, LLC JUNIOR DOT AND INTERNAL REVENUE SERVICE, GLOBAL IRS OFFICE AND ESTANAULA TRAILS HOMEOWNERS ASSOCIATION, INC AND JUDGMENT IN FAVOR OF CRYE-LEIKE REALTORS, INC

THIS IS AN ATTEMPT TO COLLECT A DEBT AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

If applicable, the notice requirements of T.C.A. 35-5-117 have been met.

All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.

If the U.S. Department of Treasury/IRS, the State of Tennessee Department of Revenue, or the State of Tennessee Department of Labor or Workforce Development are listed as Interested Parties in the advertisement, then the Notice of this foreclosure is being given to them and the Sale will be subject to the applicable governmental entities' right to redeem the property as required by 26 U.S.C. 7425 and T.C.A. §67-1-1433.

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded at any time. If the sale is set aside for any reason, the Purchaser at the sale shall be entitled only to a return of the deposit paid. The Purchaser shall have no further recourse against the Mortgagor, the Mortgagee or the Mortgagee's attorney.

MWZM File No. 14-004138-670

JASON S. MANGRUM, JOHN R. ROAN, or JERRY A. BRIDENBAUGH, Substitute Trustee(s)
PREMIER BUILDING, SUITE 404
5217 MARYLAND WAY
BRENTWOOD, TENNESSEE 37027
PHONE: (615) 238-3630
EMAIL: TNSALES@MWZMLAW.COM

SUBSTITUTE TRUSTEE'S SALE

Sale at public auction will be on June 24, 2016 on or about 12:00PM local time, at the Southwest Corner, Adams Avenue Entrance of the Shelby County Courthouse, Memphis, Tennessee, conducted by the Substitute Trustee as identified and set forth hereinbelow, pursuant to Deed of Trust executed by GEORGIA SHORE, to WESLEY D. TURNER, Trustee, on May 26, 2004, as Instrument No. 04095189 in the real property records of Shelby County Register's Office, Tennessee.

Owner of Debt: DEUTSCHE BANK NATIONAL TRUST COMPANY, AS TRUSTEE FOR AMERIQUEST MORTGAGE SECURITIES INC., ASSET-BACKED PASS-THROUGH CERTIFICATES, SERIES 2004-R8

The following real estate located in Shelby County, Tennessee, will be sold to the highest cash bidder subject to all unpaid taxes, prior liens and encumbrances of record:

LOT 19, C.M. BOOTH SUBDIVISION OF PART OF LOT 9, OF THE THOMAS W. WILLIAMS SUBDIVISION, AS SHOWN ON PLAT OF RECORD IN PLAT BOOK 33, PAGE 18, OF THE REGISTER'S OFFICE OF SHELBY COUNTY, TENNESSEE, TO WHICH PLAT REFERENCE IS HEREBY MADE FOR A MORE PARTICULAR DESCRIPTION OF SAID PROPERTY.

THE SOURCE OF THE BORROWER'S INTEREST IN THE FOREGOING DESCRIBED PROPERTY WAS A WARRANTY DEED RECORDED IN INSTRUMENT GD 9076 OF THE REGISTER'S OFFICE OF SHELBY COUNTY, TN.

Tax ID: G0244G0E000190

Current Owner(s) of Property: GEORGIA SHORE

The street address of the above described property is believed to be 335 SYCAMORE ROAD, COLLIERVILLE, TN 38017, but such address is not part of the legal description of the property sold herein and in the event of any discrepancy, the legal description referenced herein shall control.

SALE IS SUBJECT TO OCCUPANT(S) RIGHTS IN POSSESSION.

THE RIGHT IS RESERVED TO ADJOURN THE DAY OF THE SALE TO ANOTHER DAY, TIME AND PLACE CERTAIN WITHOUT FURTHER PUBLICATION, UPON ANNOUNCEMENT AT THE TIME AND PLACE FOR THE SALE SET FORTH ABOVE. THE TRUSTEE/SUBSTITUTE TRUSTEE RESERVES THE RIGHT TO RESCIND THE SALE. IF THE SALE IS SET ASIDE FOR ANY REASON, THE PURCHASER AT THE SALE SHALL BE ENTITLED ONLY TO A RETURN OF THE DEPOSIT PAID. THE PURCHASER SHALL HAVE NO FURTHER RECOURSE AGAINST THE GRANTOR, THE GRANTEE, OR THE TRUSTEE.

OTHER INTERESTED PARTIES: MERS

THIS IS AN ATTEMPT TO COLLECT A DEBT AND ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.

If applicable, the notice requirements of T.C.A. 35-5-117 have been met.

All right of equity of redemption, statutory and otherwise, and homestead are expressly waived in said Deed of Trust, and the title is believed to be good, but the undersigned will sell and convey only as Substitute Trustee.

If the U.S. Department of Treasury/IRS, the State of Tennessee Department of Revenue, or the State of Tennessee Department of Labor or Workforce Development are listed as Interested Parties in the advertisement, then the Notice of this foreclosure is being given to them and the Sale will be subject to the applicable governmental entities' right to redeem the property as required by 26 U.S.C. 7425 and T.C.A. §67-1-1433.

This property is being sold with the express reservation that the sale is subject to confirmation by the lender or trustee. This sale may be rescinded at any time. If the sale is set aside for any reason, the Purchaser at the sale shall be entitled only to a return of the deposit paid. The Purchaser shall have no further recourse against the Mortgagor, the Mortgagee or the Mortgagee's attorney.

MWZM File No. 16-000741-670

JASON S. MANGRUM, JOHN R. ROAN, or JERRY A. BRIDENBAUGH, Substitute Trustee(s)
PREMIER BUILDING, SUITE 404
5217 MARYLAND WAY
BRENTWOOD, TENNESSEE 37027
PHONE: (615) 238-3630
EMAIL: TNSALES@MWZMLAW.COM

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties in accordance with T.C.A. § 68-11-1601 et seq. and the Rules of the Health Services and Development Agency that Bartlett ASC, LLC an ambulatory surgical treatment center owned by: Bartlett ASC, LLC an ownership type of limited liability company and to be managed by: USP Tennessee Inc. intends to file an application for a Certificate of Need for: The establishment of an ambulatory surgical treatment center to provide outpatient surgery services on land which is located at 0 Kaza Bend Boulevard Bartlett, Shelby County, Tennessee 38133 (address to be assigned). No licensed beds will be affected, and no major medical equipment will be purchased as a result of this project. The cost of this project is estimated to be $7,150,000.

The anticipated date of filing the application is: May 12, 2016. The contact person for this project is: Ken H. Looney, Attorney, who may be reached at: Waller Lansden Dortch & Davis, LLP, 511 Union Street, Suite 2700, Nashville, TN 37219, 615 850-8722.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. §§ 68-11-1601 et seq. and the Rules of the Health Services and Development Agency, that AseraCare Health Resources (a proposed home health agency), to be owned and managed by AseraCare Health Resources, LLC (a limited liability company), intends to file an application for a Certificate of Need to establish a home health agency and to provide home health services, exclusively limited to the home infusion of immune globulin pharmaceuticals, in the following West Tennessee counties as a CON(s) estimated at $69,828.: Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson Henderson, Hardin, Haywood, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton, and Weakley Counties

The applicant seeks a license as a Home Health Agency (limited as described above) by the Board for Licensing Health Care facilities. The applicant's principal office will be located at 5100 Poplar Avenue, 27th Floor, Suite 2729, Memphis, TN 38137. The project does not contain major medical equipment or initiate or discontinue any other health services and it will not affect any facility's licensed bed complements.

The anticipated date of filing the application is on or before May 12, 2016. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 345-2322.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Pursuant to TCA Sec. 68-11-1607(c)(1) (A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

PEANUTS By Charles M. Schulz

CRANKSHAFT By Tom Batiuk & Chuck Ayers

FRANK & ERNEST By Bob Thaves

BORN LOSER By Art and Chip Sansom

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: UNITED SURGICAL PARTNERS INTERNATIONAL

I, KIM H. LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 13 day of May, 2016, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires:

CARMEN M. SALAZAR
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON
MY COMMISSION EXPIRES: JULY 8, 2017

HF-0043

Revised 7/02

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

July 1, 2016

Kim Looney, Esq.
Waller Lansden
511 Union Street, Suite 2700
Nashville, TN 37219

RE: Certificate of Need Application -- Bartlett ASC, LLC - CN1605-020
The establishment of a specialty ambulatory surgical center (ASTC) providing outpatient surgery services at 0 Kate Boulevard, Bartlett (Shelby County), TN 38133. The estimated project cost is $9,837,855.48.

Dear Ms. Looney.:

This is to acknowledge the receipt of supplemental information to your application for a Certificate of Need. Please be advised that your application is now considered to be complete by this office.

Your application is being forwarded to Trent Sansing at the Tennessee Department of Health for Certificate of Need review by the Division of Policy, Planning and Assessment. You may be contacted by Mr. Sansing or someone from his office for additional clarification while the application is under review by the Department. Mr. Sansing's contact information is Trent.Sansing@tn.gov or 615-253-4702.

In accordance with Tennessee Code Annotated, §68-11-1601, et seq., as amended by Public Chapter 780, the 60-day review cycle for this project will begin on July 1, 2016. The first 60 days of the cycle are assigned to the Department of Health, during which time a public hearing may be held on your application. You will be contacted by a representative from this Agency to establish the date, time and place of the hearing should one be requested. At the end of the 60-day period, a written report from the Department of Health or its representative will be forwarded to this office for Agency review. You will receive a copy of their findings. The Health Services and Development Agency will review your application on October 26, 2016.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. § 68-11-1607(d):

(2) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(3) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have questions or require additional information, please contact me.

Sincerely,

Melanie M. Hill
Executive Director

cc: Trent Sansing, TDH/Health Statistics, PPA

State of Tennessee
Health Services and Development Agency
Andrew Jackson, 9th Floor, 502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

MEMORANDUM

TO: Trent Sansing, CON Director
Office of Policy, Planning and Assessment
Division of Health Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, Tennessee 37243

FROM: Melanie M. Hill
Executive Director

DATE: July 1, 2016

RE: Certificate of Need Application
Bartlett ASC, LLC - CN1605-020

Please find enclosed an application for a Certificate of Need for the above-referenced project.

This application has undergone initial review by this office and has been deemed complete. It is being forwarded to your agency for a 60-day review period to begin on July 1, 2016 and end on September 1, 2016.

Should there be any questions regarding this application or the review cycle, please contact this office.

Enclosure

cc: Kim Looney, Esq.

State of Tennessee
Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364 Fax: 615-741-9884

LETTER OF INTENT

The Publication of Intent is to be published in the Commercial Appeal (Name of Newspaper) which is a newspaper of general circulation in Shelby (County), Tennessee, on or before May 10 (Month/Day), 2016 (Year) for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that:

Bartlett ASC, LLC (Name of Applicant) an ambulatory surgical treatment center (Facility Type-Existing)

owned by: Bartlett ASC, LLC with an ownership type of limited liability company

and to be managed by: USP Tennessee, Inc. intends to file an application for a Certificate of Need

for [PROJECT DESCRIPTION BEGINS HERE]: The establishment of an ambulatory surgical treatment center to provide outpatient surgery services on land which is located at 0 Kate Bond Boulevard, Bartlett, Shelby County, Tennessee 38133 (address to be assigned). No licensed beds will be affected, and no major medical equipment will be purchased as a result of this project. The cost of this project is estimated to be $7,150,000.

The anticipated date of filing the application is: May 12, 2016

The contact person for this project is Kim H. Looney (Contact Name) Attorney (Title)

who may be reached at: Waller Lansden Dortch & Davis LLP (Company Name) 511 Union Street; Suite 2700 (Address)

Nashville (City) TN (State) 37219 (Zip Code) 615 (Area Code) / 850-8722 (Phone Number)

Kim H. Looney (Signature) May 10, 2016 (Date) Kim.Looney@wallerlaw.com (Email-Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Supplemental #1
-Original-

Bartlett ASC, LLC

CN1605-020

waller

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 700
Nashville, TN 37219-8966

615.244.6380 main
615.244.6804 fax
wallerlaw.com

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

May 26, 2016

VIA HAND DELIVERY
Phillip M. Earhart
Health Services Development Examiner
Andrew Jackson Bldg - 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: Certificate of Need Application CN1605-020
Bartlett ASC, LLC

Dear Mr. Earhart:

In response to your request for additional information, please find our responses to supplement the Certificate of Need for the establishment of a specialty ambulatory surgical center (ASTC) providing outpatient surgery services at 0 Kate Bond Boulevard, Bartlett (Shelby County), TN 38133 filed with your office on May 13, 2016. Please note that we are missing the documents in response to Question 1 and the information on equipment over $50,000 in Question 12, which we will provide as soon as we receive.

---

1. **Section A, Item 6**

   The response to this item is noted. Please provide a fully executed Option to Lease (signed by both parties) that at least includes the name of the landlord, the expected term of the lease and the anticipated lease payments.

   Please provide documentation that ValFund has a deed to the property.

   RESPONSE: The term of the lease is 10 years.

2. **Section B, Project Description, Item I**

   It is noted the applicant will lease the project from the Developer Valfund. Please provide an overview of the developer including the following:
   - Brief history and mission of the Fund.
   - An overview of the Operating entity of ValFund
   - Please provide a brief description of Valfund's expertise in developing an ASTC.
   - Overview of recent Valfund developments and/or transactions.

- Brief Bio of the managing member of Value Acquisition Fund

RESPONSE: Please see a description of ValFund, a list of recent projects and a brief bio of the managing member of Value Acquisition Fund included as Attachment B, Project Description, I.

Please discuss in detail the arrangement of not owning and developing the project, but leasing the ASTC space from a developer run entity.

RESPONSE: The benefit of not owning and developing the project, but leasing the ASTC space from a developer run entity, is that the developer is expending its capital – either directly or through borrowed funds – and is at risk and that the applicant does not tie up its capital or have the risk associated with developing and owning the property.

3. **Section B, Project Description, Item II A**

It appears the proposed project's construction cost exceeds $2,000,000. If correct, please complete the Square Footage and Cost per Square Footage Chart.

RESPONSE: The applicant does not have the information at this level of detail because the developer will be constructing the building.

4. **Section B, Project Description Item III.A.(Plot Plan)**

Please provide a new Plot Plan with all the required information. As required for all projects, a Plot Plan must provide **the size of the site (in acres), location of the structure on the site, the location of the proposed construction, and the names of streets, roads, highways that cross or border the site**.

RESPONSE: Please see a copy of the plot plan included as Attachment B, Project Description-III.A-4.

5. **Section C, Need, Item 1.a (Service Specific Criteria-ASTC)**

Please indicate the total number of surgical cases and pain management epidural procedures in Year Three of the proposed project.

RESPONSE: The applicant anticipates that there will be approximately 2,034 surgical cases and 1,850 - 1,900 pain management epidural procedures in Year 3 of the proposed project.

6. **Section C, Need, Item 1.a (Service Specific Criteria-ASTC)**

The table of Projected Surgical Hours for Year 1 and Year 2 on the top of page 14 is noted. However, please add a column for Year One and Year Two that shows the surgical capacity in hours for each row.

RESPONSE: Please see the chart below with the additional columns.

	Year 1				Year 2			
	Cases	Time/Case	Total Hours	Capacity in Hours	Cases	Time/Case	Total Hours	Capacity in Hours
Projected Surgical Cases	1,230	1:30	1,845	4,000	1,993	1:30	2,990	4,000
Projected Pain Mgmt Cases	755	0:45	566	2,000	1,224	0:45	918	2,000
Total Cases	1,985	0:15	496		3,217	0:15	804	
Total Time in Hours			2,907	6,000			4,712	6,000

7. **Section C, Need, Item 1.a (Service Specific Criteria-ASTC (3)**

Please complete the following table for the proposed service area ASTCs.

Multi-Specialty	2013	2014	2015	% Change from 13-15
Operating Rooms	42	42	42	0
Cases	33,827	28,360	32,719	(3.3)
Case Per OR	805	675	779	(3.2)
Procedure Rooms	11	11	11	0
Cases	12,886	12,785	13,341	3.5
Cases Per PR	1,171	1,162	1,213	3.6
Single-Specialty	2013	2014	2015	% Change from 13-15
Operating Rooms	23	24	23	0
Cases	24,126	23,506	24,364	.99
Case Per OR	1,049	979	1,059	.95

Procedure Rooms	29	28	32	10.3
Cases	48,841	43,469	49,379	1.1
Cases Per PR	1,684	1,552	1,543	(8.4)

Using the ASTC Data System, please complete the following table for ASTC patient origin by ZIP code region and County for CY 2015.

RESPONSE: The ASTC data has been requested from the Tennessee Department of Health. However, the data has not yet been received. Therefore, the Tennessee Joint Annual Reports have been used to provide data at the county level.

ASTC cases by Residents of Applicant's Proposed ZIP Code Region and County Service Area, 2015

Facility	*ZIP Code Region	% Total	Shelby County	%Total	Fayette County	% Total
Multi-specialty Ambulatory Surgical Treatment Centers						
Baptist Germantown Surgery Center	N/A	N/A	2,307	71.3%	111	3.4%
Campbell Clinic Surgery Center Midtown	N/A	N/A	426	32.2%	5	0.4%
Campbell Clinic Surgery Center	N/A	N/A	4,129	56.9%	219	3.0%
East Memphis Surgery Center	N/A	N/A	2,863	62.9%	130	2.9%
Le Bonheur East Surgery Center, II	N/A	N/A	1,328	60.1%	54	2.4%
Memphis Surgery Center	N/A	N/A	1,746	71.3%	52	2.1%
Methodist Surgery Germantown Center	N/A	N/A	3,180	70.9%	127	2.8%
North Surgery Center	N/A	N/A	1,915	70.3%	60	2.2%
Semmes-Murphey Clinic	N/A	N/A	1,928	45.6%	117	2.8%
Surgery Center at Saint Francis	N/A	N/A	3,362	58.7%	0	0.0%
Single-specialty Ambulatory Surgical Treatment Centers						
Endoscopy Center of the Mid-South	N/A	N/A	483	46.0%	0	0.0%
Eye Care Surgery Center of Memphis	N/A	N/A	587	72.9%	46	5.7%
Germantown Ambulatory Surgical Center	N/A	N/A	65	61.3%	2	1.9%

Facility	*ZIP Code Region	% Total	Shelby County	%Total	Fayette County	% Total
GI Diagnostic and Therapeutic Center	N/A	N/A	9,793	69.6%	480	3.4%
Hamilton Eye Institute Surgery Center	N/A	N/A	1,679	55.7%	49	1.6%
Mays and Schnapp Pain Clinic and Rehabilitation Center	N/A	N/A	999	52.3%	101	5.3%
Memphis Center for Reproductive Health	N/A	N/A	1062	50.0%	13	0.6%
Memphis Eye and Cataract Ambulatory Surgery Center	N/A	N/A	954	68.9%	57	4.1%
GI Diagnostic and Therapeutic Center (Memphis Gastroenterology Endoscopy Center East)	N/A	N/A	5,975	66.0%	530	5.9%
Mid-South Gastroenterology Group	N/A	N/A	6,328	84.3%	0	0.0%
Mid-South Interventional Pain Institute	N/A	N/A	481	53.9%	26	2.9%
Planned Parenthood Greater Memphis Region, Inc.	N/A	N/A	2,077	62.7%	38	1.1%
Ridge Lake Ambulatory Surgery Center	N/A	N/A	1.841	66.3%	52	1.9%
Shea Clinic	N/A	N/A	0	0.0%	0	0.0%
UroCenter	N/A	N/A	1,692	55.7%	103	3.4%
Wesberry Surgery Center	N/A	N/A	349	91.8%	5	1.3%
Wolf River Surgery Center	N/A	N/A	2,655	66.8%	123	3.1%

SOURCE: Tennessee Department of Health, Joint Annual Report of ASTCs, 2015.

*ZIP Code Region: ***(38134, 38002, 38135, 38016, 38133, 38128, 38053, 38127, 38068, 38060, 38018, 38122, 38019, 38004, 38058, 38011, 38108, 38028, 38023, 38049, 38111)***

Using the Hospital Discharge Data System, please complete the following table for outpatient hospital surgeries by patient origin by ZIP code Region and County for CY 2015.

RESPONSE: The outpatient surgery data from the Hospital Discharge Data System has been requested from the Tennessee Department of Health. However, the data has not yet been received. The Joint Annual Report Data for hospitals does not provide outpatient surgery data at the zip code level.

OP Hospital Surgery cases by Residents of Applicant's Proposed ZIP Code Region and County Service Area, 2015

Facility	ZIP Code Region	% Total	Shelby County	%Total	Fayette County	% Total

8. **Section C, Need, Item 1.a (Service Specific Criteria-ASTC (4)**

It is noted the applicant anticipates the proposed surgery center will have the greatest impact on Saint Francis Hospital, Saint Francis Surgery Center, and Saint Francis Hospital-Bartlett. However, please provide a measurable analysis of the impact. For example, how many estimated surgical cases will be reduced at each provider if this proposed project is approved?

RESPONSE: The projected number of surgical cases in the first year is 1,230. The applicant anticipates the following reductions:

SFH - Memphis: 50 - 80
SFH - Bartlett: 40 - 80
Surgery Center at Saint Francis: 530 - 550

It has been USPI's experience that if you have commitments from a particular physician group – in this situation Tabor Orthopedics – and about half of the projected volume can be attributed to them, then other physicians will follow suit when the project has been approved and syndication occurs.

9. **Section C, Need, Item 1.a (Service Specific Criteria-ASTC (8)**

Please complete the following tables that reflect the origin of potential patients by percentage from the applicant's proposed Zip Code and County service area.

Area Zip code	Year One	% of total
38134	216	10.9
38002	179	9.0
38135	177	8.9
38016	173	8.7
38133	143	7.2
38128	123	6.2
38053	109	5.5
38127	73	3.7
38068	62	3.1
38060	60	3.0
38018	55	2.8
38122	36	1.8
38019	34	1.7
38004	32	1.6
38058	32	1.6
38011	32	1.6
38108	27	1.4
38028	26	1.3
38023	24	1.2
38049	22	1.1
38111	18	0.9
Other-Shelby County	228	11.5
Fayette County	49	2.5
Other	55	2.8
Total	**1,985**	**100%**

Please note that the Bartlett zip codes, 38133, 38134 and 38135 account for 27% of the projected patient origin.

10. Section C, Need, Item 4.A.

Please include Fayette County and totals for the entire service area in the tables on pages 27 and 28 and resubmit.

RESPONSE: Please see replacement pages 27 and 28 with revised charts which include Fayette County included as Attachment C, Need, 4.A.

11. Section C, Need Item 6

Please document referral sources in Projecting 1,985 cases in Year One and 3,217 in Year Two.

RESPONSE: A significant number of the projected surgical cases, as well as the pain management procedures, is based on the interest of Tabor Orthopedics. Tabor Orthopedics is a group of 8 orthopedic specialists and one pain management specialist. Tabor Orthopedics also anticipates that its group will grow in the next few years. As the plot plan shows, Tabor Orthopedics plans to relocate its medical offices to the portion of the plot plan that is labelled "Clinic". The majority of the outpatient surgeries currently performed by this group are performed at either Saint Francis Hospital, SFH-Bartlett or the Surgery Center at Saint Francis. Approximately 50-60% of the projected volume in the first year is expected to come from Tabor Orthopedics. It has been USPI's experience that if you have commitments that will account for approximately half of your projected volume at an ASTC, which in this situation is Tabor Orthopedics, that other physicians will follow suit when the project has been approved and syndication occurs. The projections have been based in part on the experience of USPI, which owns and operates, and/or manages ASTCs across the country, including 23 in Tennessee. USPI forms partnerships with prominent physicians and/or leading health systems, just as in this situation.

Please complete the following table breaking out Projected cases between OR and PR in Year One and Year Two of the proposed project.

	2017	2018
OR #1	614	996
OR #2	615	997
PR #1	755	1,224
Cases	1,229	1,993
Cases/room	615	997
Procedures	755	1,224
Procedures/room	755	1,224

12. Section C, Economic Feasibility, Project Costs Chart

Please list any equipment over $50,000 in cost.

RESPONSE:

Please clarify the need for $650,000 in working capital and what it will be used for.

RESPONSE: The working capital will be used for the pre-opening expenses of $378,755 listed on the Project Costs Chart and to fund the period of time in which the ASTC is fully staffed and equipped, but the caseload has not yet increased to the volume at which the ASTC has positive cash flow. The working capital will be used to cover any shortfall in expenses during this time. The working capital will be funded from cash as described in the response to Question 13 below.

13. Economic Feasibility, Item 2, Project Funding

It is noted the applicant is not developing the project but anticipates leasing the building from the developer. However, the facility lease amount is designated at $1,683,259. Please identify the source of the funding for the remainder of the Project Costs in the amount of $7,154,506.40 and what entity will be responsible for payment. If necessary, please revise page 34 (funding for the Project) and submit.

RESPONSE: The facility lease amount as shown on the Project Cost Chart is $2,683,250. The applicant has included a Revised Page 34 included as Attachment C, Economic Feasibility, 2 that indicates it will be receiving a commercial loan for part of the Project Costs. The applicant anticipates that it will receive cash from USPI in the amount of $2,000,000 and another $2,000,000 in cash when it syndicates the surgery center for a total of $4,000,000 in cash. The working capital amount will come from this cash amount. Any remaining amount of Project Costs is expected to be funded through a commercial loan. Please see a letter from the CFO for USPI indicating the cash is available and expected to be used for this project and a commercial loan letter indicating interest in financing the project, included as Attachment C, Economic Feasibility, 2.

It is noted the developer ValFund will be constructing the proposed ASTC building. Please provide appropriate documentation (letter) of funding for the proposed project from the Chief Financial Officer of ValFund. If ValFund plans to finance the proposed project by a commercial loan, please provide documentation from a lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions. If the project will be financed by ValFund with cash, please provide appropriate documentation from a financial institution or Certified Public Accountant of the availability of required cash for the proposed project.

RESPONSE: The applicant does not have access to any information related to ValFund's funding for the construction costs.

It is noted the facility lease in the Project Costs Chart is $2,683,250. However, the square footage cost of the project calculates to $2,936,250 (13,500 SF x $217.50). Please clarify why the lower amount was used in the Project Costs Chart. The following definition regarding items acquired by lease in Tennessee Health Services and Development Agency Rule 0720-2-.01 (12)(d) states " If the acquisition is by lease, the cost is either the fair market value of the property, or the total amount of the lease payments, whichever is greater."

RESPONSE: The lease amount included in the Project Cost Chart is the Net Present Value of the lease payments. The lease amount is not financed but will be paid out of current operating revenues. The applicant has included the Tenant Improvements in

addition to the lease cost in the Project Cost Chart. The applicant believes that the project costs listed are greater than the FMV of the property, but does not have access to those numbers.

14. Economic Feasibility, Item 3

Please compare the new construction cost (not total construction) per GSF to other ASTC projects for Years 2012-2014 using the applicant's toolbox on HSDA's web-site located at http://tennessee.gov/hsda/applicants_tools/app_tool_box.shtml

Please indicate how the applicant derived a new construction cost of $217.50 per square foot.

RESPONSE: The applicant received the data necessary to calculate the new construction cost of $217.50 per square foot from the architect. The HSDA's toolbox currently only has data for 2012-2015, and per the document published as of 4/25/2016, the ASTC data has an insufficient sample size to provide construction ranges. Therefore, there are currently no available published construction cost ranges to compare the project to. Prior to 4/25/2016, data for 2012-2014 was available. However, the published document stated that there was insufficient sample size to calculate both renovated and new construction ranges. Therefore, the HSDA Construction Cost per Square Foot Chart for ASTCs only contained total construction costs. Please see 2012-2014 and 2013-2015 Construction Cost Per Square Foot Charts included as Attachment C, Economic Feasibility, 3. To the extent the data includes both renovated and new construction costs, the figure may be lower than if only new construction costs were used.

15. Economic Feasibility, Item 4, Projected Data Chart

Please indicate the number of cases projected in Year One and Year Two on line A. Utilization Data in the Projected Data Chart.

RESPONSE: Please see the replacement page with the revised Projected Data Chart identifying the measure as cases included as Attachment C, Economic Feasibility, 4.

It is noted in the management agreement the management fee will equal 7% of net revenues. However, the percentage applied to the Projected Data Chart in Year One and Year Two does not match the management agreement percentage fee. Please clarify.

RESPONSE: The management fee rate of 6.5% of net revenue as applied to the Projected Data Chart is the correct rate. However, the rate in the draft management agreement was inadvertently listed as 7% of net revenues. Please find a corrected draft management agreement with the 6.5% rate included as Attachment A-5.

Why is there interest of $144,052 in Year Two?

RESPONSE: The $144,052 interest listed in Year Two was incorrectly duplicated and should only have appeared in the capital expenditures section. Please see the revised Projected Data Chart included as Attachment C, Economic Feasibility, 4.

The applicant incorrectly refers to "page 12" for a listing of "D.9 other expenses". Please revise.

RESPONSE: The reference has been corrected.

There appears to be calculation errors in the Year 1 and Year 2 columns. Please correct and resubmit a replacement page.

RESPONSE: Please see the replacement page with the revised Projected Data Chart included as Attachment C, Economic Feasibility, 4.

Please clarify the reason there are Capital Expenditures while the applicant has not designated any funding sources for the proposed project.

RESPONSE: Please see response to Question 13 above describing the funding for the project.

16. Section C., Economic Feasibility, Item 5

Please add charity care and contractual adjustments into gross revenue and designate those amounts under "deductions from Gross Operating Revenue.

RESPONSE: Please see Revised Projected Data Chart included as Attachment C, Economic Feasibility, 4.

Your response is noted. Please complete the following table identifying the project's gross charge, average deduction from operating revenue, and average net charge per case. The applicant should divide the total patient cases in Year One of the Projected Data Chart into the total gross charges, deductions from operating revenue total, and total net charges to calculate the charges.

RESPONSE: Please see table below. Please note that the numbers do not match exactly what has been included in the application because these numbers have been rounded.

	Year One	Year Two

	Year One	Year Two
Average Gross Charge (Gross charges/total cases)	$3,213	$2,904
Average Deduction (Total Deductions/total cases)	490	433
Average net Charge Total Net Operating Revenue/total cases)	$2,723	$2,471

17. Section C, Economic Feasibility, Item 6.A

It is noted the applicant projects $4.7 million in gross revenue at the top of page 39 in Year One. However, the Projected Data Chart projects approximately $5.57 million in gross revenue. Please clarify.

RESPONSE: The $4.7M that was listed as the projected revenue in the first year of operations was an inadvertent typo in response to Section C, Economic Feasibility, Item 6.A. The applicant has projected gross revenue of $6,378,033 in its first year of operations as shown on the Revised Projected Data Chart.

18. Section C, Economic Feasibility, Item 8

The applicant expects the parent company Tenet to contribute cash reserves to cover negative operating income in Year One. Please provide appropriate documentation (letter) of the funding commitment by cash reserves from Tenet's Chief Financial Officer to cover the shortfall amount.

RESPONSE: The information included in the application is not correct. Please see response to Question 13 above for a description of the project funding.

19. Section C, Economic Feasibility, Item 9

Please complete the following chart for Year One of the proposed project using revised gross charges (that includes charity care and contractual adjustments) from the revised Projected Data Chart.

Payor	Gross Revenue	% of Total Revenues
Medicare	$ 668,688	12.0
Medicaid/TennCare	$ 81,943	1.3

Payor	Gross Revenue	% of Total Revenues
Commercial insurance	$5,460,230	85.6
Self-Pay	0	0

20. Section C (Contribution to Orderly Development) Item 3.

What impact will project have on outpatient surgery at SF-Bartlett and other hospitals in service area?

RESPONSE: Please see response to Question 8 above for the impact to SFH and SFH-Bartlett. The applicant does not anticipate having a significant impact on other hospitals in the service area. Because it feels any impact on other hospitals in the service area will be negligible, it has not projected any impact.

21. Section C (Contribution to Orderly Development) Item 3. (Current & Anticipated Staffing)

Please complete the following staffing chart for the proposed project.

Staffing	Proposed (FTE)
Registered Nurse	9.0
Surgical Technologists	5.0
Other	4.0
Total	18.0

22. Section C, Orderly Development, Item 8 and 9

The applicant responded "not applicable" to questions 8 and 9. Please provide a narrative response to items 8 and 9.

RESPONSE: Please see revised responses to Questions 8 and 9 below.

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

RESPONSE: There are none.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.

RESPONSE: There are none.

23. Proof of Publication

Please submit a copy of the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

RESPONSE: Please see the publication affidavit included as Attachment C, Contribution to the Orderly Development of Health Care – Publication Affidavit.

24. Project Completion Forecast Chart

Please submit a completed Project Completion Forecast Chart.

RESPONSE: Please see the completed Project Completion Forecast Chart included as Attachment C, Contribution to the Orderly Development of Health Care – Project Completion Forecast Chart.

Very truly yours,

Kim H. Looney

KHL:mk
Enclosures

SUPPLEMENTAL #1
May 26, 2016
8:14 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: BARTLETT ASC, LLC

I, KIM LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title
KIM H. LOONEY, ATTORNEY

Sworn to and subscribed before me, a Notary Public, this the 26th day of May, 2016, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires _____, _____.

CARMEN M. SALAZAR
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON
MY COMMISSION EXPIRES: JULY 3, 2017

HF-0043

Revised 7/02

SUPPLEMENTAL #1
May 26, 2016
8:14 am

Attachment A-5

Draft Management Agreement

SUPPLEMENTAL #1
May 26, 2016
8:14 am

MANAGEMENT AGREEMENT
(_____ Surgery Center)

This Management Agreement ("Agreement") is made and entered into effective as of this ___ day of _____, 201_ ("Effective Date") by and between USP _____, Inc., a _____ corporation ("Manager"), and _____, [LLC] [L.P.], a _____ limited [liability company] [partnership] (the "Company"), with reference to the following facts:

RECITALS

A. Manager owns an interest in the Company.

B. The Company is [developing] [acquiring] and will operate [an ambulatory surgery center] [a surgical hospital] **[to be]** known as _____, located at _____, _____ (the "Surgery Center") **[, pursuant to a Contribution and Purchase Agreement, dated _____, 20___ (the "Purchase Agreement")]**.

C. In accordance with Section ___ of the **[Limited Partnership] [Operating]** Agreement of the Company, Manager and the Company desire to enter into an agreement whereby Manager will manage the Surgery Center for the Company.

NOW, THEREFORE, for good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, intending to be legally bound, the Company and Manager hereby agree as follows:

AGREEMENT

1. Management Services.

(a) The Company hereby engages Manager, and Manager hereby accepts the engagement, to provide day-to-day management services to and for the Surgery Center, subject to oversight and control by the Company as provided in Section 1(k) below. Such services shall include but are not limited to financial and operating system management, preparation of proposed annual budgets, purchasing, managed care relationships, expansion of the Surgery Center or its services, preparation of staffing plans, recruitment of personnel and medical staff and general supervision of the day-to-day operations of the Surgery Center. In addition, Manager shall consult with the Company regarding the development of an ongoing advertising and promotion program to be implemented by the Surgery Center at the Company's sole cost and expense, it being intended that Manager shall not directly or indirectly provide marketing for the Surgery Center or bring patients or induce referrals to the Surgery Center. In this regard, Manager and the Company will consider from time to time including the Surgery Center in the business development program of Manager's affiliate, United Surgical Partners International, Inc. ("Parent"). If the Surgery Center is included in this program, the Surgery Center will be responsible for the incremental cost associated with the program.

(b) In carrying out its duties, Manager shall have authority over charges, cash flow, planning, accounts receivable and third party payor reimbursements. Manager shall have the further authority and responsibility to manage all of the departments of the Surgery Center, establish charge schedules and promulgate personnel policies, including but not limited to qualifications and criteria for hiring and discharge of personnel; provided, however, that all medical and professional matters shall be the responsibility of the Company, the Medical Director and medical staff of the Surgery Center.

(c) Manager shall do or cause to be done all acts, procedures, authorizations and any and all other matters necessary, appropriate or related to obtaining and maintaining all necessary licenses, permits, provider numbers and approvals from all regulatory authorities having jurisdiction over the Surgery Center and/or its operations and accreditation by The Joint Commission, Accreditation Association for Ambulatory Health Care ("AAAHC") or other accrediting agencies designated by the Company.

(d) Manager shall maintain one or more local bank accounts for the Company in which it shall deposit the receipts from the business of the Surgery Center. Manager shall be entitled to make withdrawals from such account to pay authorized Surgery Center expenses, including payments to Manager in accordance with Section 3 hereof. The handling of receipts and disbursements with respect to such bank accounts shall be in accordance with customary business practices. Manager shall be entitled to invest such funds in connection with any cash management system employed by Parent (or its affiliate) on behalf of its affiliated surgery centers.

(e) Manager shall design, institute, supervise and from time to time revise and amend management, operational, financial and informational systems in order to conduct the physical and administrative operations of the Surgery Center, including but not limited to those required for billing and collection of charges, accounting and purchasing. Manager shall cause to be prepared and submitted in a proper manner and in a timely fashion any cost reports required to be submitted pursuant to the requirements of third party payors or any authority having jurisdiction over the Surgery Center.

(f) In accordance with applicable law, Manager shall negotiate and consummate agreements and contracts for and on behalf of the Surgery Center in the usual course of business, including without limitation managed care contracts (subject to pricing parameters established by the Company), radiology, laboratory and anesthesia contracts and contracts of insurance pursuant to the master insurance policies and programs maintained by Parent for its affiliated surgery centers. All such insurance policies shall name as insured parties the Company, Manager and such other persons as may be requested by the Company. Manager shall promptly notify the Company of all actual or threatened legal claims or actions affecting the Company and shall coordinate all legal matters and proceedings with counsel for the Company.

(g) Subject to the terms of the Operating Agreement, Manager, Parent or one of their affiliates shall locate, select and hire (or cause to be hired by or through an affiliate, which may include the Company), all Surgery Center personnel. All such personnel shall participate in and be

compensated through the employee benefit programs and payroll systems established from time to time by or for the benefit of Parent. All Surgery Center personnel shall be supervised by Manager as provided herein, regardless of the entity that is the employer.

(h) Manager will make available to the Surgery Center programs and assistance that are generally made available by Parent to its affiliated surgery centers, including cash management programs, business office management, legal assistance from Parent's in-house attorneys, Parent's EDGE [TM] quality monitoring and assurance program, patient grievance programs, performance measurement systems, practice improvement programs, compliance plans for government regulations (including Medicare and the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("HIPAA")) and other similar programs. The services above are generally included in the management fee payable to Manager pursuant to Section 3. Parent shall be entitled to charge the Company for incremental programs and systems on the same basis that it charges other affiliated surgery centers that are not wholly owned by Parent. These services may include the Kronos management clock, approved services contracted to third parties, group-purchased services such as liability insurance, IT hosting fees, some types of approved staff training, association dues and certain satisfaction surveys.

(i) Manager shall undertake all of its obligations and duties hereunder for the account of the Company and not for the account of Manager, and Manager shall have no responsibility or liability for performing any duties that involve making payments or incurring expenses unless the Company makes adequate funds available therefor. In carrying out its duties hereunder, Manager shall be an independent contractor and shall not be subject to any right of control, or any control in fact, of the Company over the methods by which it carries out its duties. Neither this Agreement nor the exercise of any of the duties of Manager hereunder shall be deemed to create any partnership, joint venture, association or other relationship between the parties hereto other than that of independent contractors each as to the other.

(j) Manager shall have the right to act as the agent of the Company and/or the Surgery Center in the procuring of licenses, permits and other approvals, the payment and collection of accounts and in all other activities necessary or useful to Manager in the carrying out of its duties as specified in this Agreement.

(k) Anything in this Section 1 to the contrary notwithstanding, Manager expressly acknowledges and agrees that the Company at all times during the term of this Agreement shall exercise the ultimate control and direction of the operations of the Surgery Center. Manager shall operate within any reasonable parameters, policies and procedures adopted by the Company and communicated to Manager by the Company, so long as such parameters, policies and procedures do not, in Manager's reasonable judgment, jeopardize the quality of patient care provided at the Surgery Center or require Manager or the Company to engage in any illegal or unethical acts.

2. **Term; Termination.**

(a) **Term of Agreement.** The term of this Agreement shall commence on the date first above written and, unless sooner terminated as provided in this Section 2, shall continue in effect so long as Manager or an affiliate of Manager or an assignee permitted by Section 10 continues to be an owner in the Company.

(b) **Termination Upon the Mutual Agreement of the Parties.** This Agreement may be terminated at any time upon the mutual agreement of Manager and the Company.

(c) **Termination for Default.** This Agreement may be terminated in the event of a Default (as defined in Section 8 hereof) by one party, subject to any applicable cure period, upon the nondefaulting party giving written notice of termination to the defaulting party.

3. **Management Fee.**

(a) As Manager's fee for its management services hereunder, Manager shall receive monthly an amount equal to **[six and a half]** percent of the net revenues of the Surgery Center during such month (or the portion thereof during which this Agreement is in effect). For purposes of this Section 3, "net revenues" shall be the Surgery Center's gross revenues from the delivery of medical and facility services at the Center (which does not include any physician professional fees), less adjustments for special contractual rates, charity work and an allowance for uncollectible accounts, all determined in accordance with generally accepted accounting principles. The fee for each month shall be paid on or before the 15th day of the succeeding month.

(b) In addition to the above fees, Manager shall be reimbursed by the Company for out-of-pocket expenses incurred on behalf of the Company, but shall not be reimbursed for any indirect or overhead expenses of Manager or its affiliates (except for incremental costs associated with Parent's business development program, if the Surgery Center is included in the program, as described in Section 1(a) hereof). Such reimbursement shall include, but is not limited to, all costs to Manager of providing the Surgery Center employees pursuant to Section 1(g) hereof (including without limitation all compensation and employee benefit costs) and reasonable travel expenses of corporate personnel of Parent and its affiliates who make periodic business trips to the Surgery Center.

(c) Except as otherwise provided in this Agreement, all of the costs and expenses of maintaining and operating the Surgery Center and its facilities shall be expenses of the Surgery Center, for the account of the Company, and shall not be expenses of Manager.

4. **Books and Records.**

(a) Manager shall supervise the maintenance of the books of account covering the operations of the Surgery Center. The general ledger may, if Manager so elects, be maintained by Manager through any centralized accounting system maintained by Parent. Such

books of account shall be maintained on an accrual basis in accordance with generally accepted accounting principles consistently applied.

(b) Manager shall prepare and furnish to the Company after the close of each fiscal quarter an unaudited financial statement reflecting the operations of the Company for such quarter. Manager shall cause to be prepared and furnished after the close of each fiscal year an unaudited balance sheet of the Company dated as of the end of the fiscal year and a related statement of income or loss for the Company for such fiscal year, all of which may (if the Company so elects) be certified in the customary manner by an independent certified public accountant approved by the Company. The expense of any such independent accountants shall be borne by the Company.

(c) Authorized agents of the Company shall have the right at all reasonable times during usual business hours to audit, examine and make copies of or extracts from the books of account of the Company maintained by Manager. Such right may be exercised through any agent, independent public accountant or employee of the Company designated by the Company. The Company shall bear all expenses incurred in any examination it makes pursuant hereto.

(d) If this Agreement is determined at any time during its term to be subject to the provisions of 42 Code of Federal Regulations, or any successor regulation which governs access to books and records of subcontractors of services to Medicare providers with a value or cost of $10,000 or more during a 12 month period, then Manager and its subcontractors shall make available, upon the request of the Secretary of Health and Human Services or the Comptroller General, the contracts, books, documents, and records necessary to verify the nature and extent of the cost of providing Medicare services under this Agreement, if any; provided, however, that any applicable attorney-client accountant-client or other legal privilege shall not be deemed waived by virtue of this Section 4(d). Such inspection shall be available up to four years after the rendering of such services.

5. Representations of Manager. Manager represents and warrants that it has been duly organized and is validly existing as a corporation in good standing under the laws of the State of _____, with full corporate power to own its properties and to conduct its business under such laws.

6. Use of Name, Logos, etc.. During the term of this Agreement, Manager shall have the right to utilize the name, trademarks, logos and symbols identifying the Surgery Center, including the right to represent to the public and the health care industry that the facilities and operations of the Surgery Center are managed by Manager. The Company shall not however, make any use of the name of Manager or Parent, or any of their trademarks, logos or symbols, without the prior written consent of Manager.

7. Indemnification. Manager does not hereby assume any of the obligations, liabilities or debts of the Company or the Surgery Center, except as otherwise expressly provided herein, and shall not, by virtue of its performance hereunder, assume or become liable for any of such obligations, debts or liabilities of the Company or the Surgery

Center. The Company hereby agrees to indemnify, defend and hold Manager harmless from and against any and all claims, actions, liabilities, losses, costs and expenses of any nature whatsoever, including reasonable attorneys' fees and other costs of investigating and defending any such claim or action, asserted against Manager on account of any of the obligations, liabilities or debts of the Company or the Surgery Center. The Company further agrees to defend, hold harmless and indemnify Manager and its officers, directors, employees and agents from and against any and all claims, actions, liabilities, losses, costs and expenses of any kind imposed on account of or arising out of actions taken in good faith by Manager or its officers, directors, employees or agents in what Manager or any such person reasonably believed to be within the scope of their responsibilities under this Agreement so long as such actions do not constitute gross negligence or intentional misconduct by the party requesting indemnification.

8. Default. The following events shall each constitute a "Default" under this Agreement: (a) the filing by either party hereto of a voluntary petition in bankruptcy or for reorganization under any bankruptcy law, or a petition for the appointment of a receiver for all or any substantial portion of the property of either party hereto, or any voluntary or involuntary steps to dissolve or suspend the corporate powers of either party unless such steps to dissolve or suspend are promptly removed; (b) the consent by either party hereto to an order for relief under the federal bankruptcy laws or the failure to vacate such an order for relief within 60 days from and after the date of entry thereof; (c) the entry of any order, judgment or decree, by any court of competent jurisdiction, on the application of a creditor, adjudicating either party hereto as a bankrupt, or to be insolvent, or approving a petition seeking reorganization or the appointment of a receiver, trustee or liquidator of all or a substantial part of such entity's assets, if such order, judgment or decree shall continue unstayed and in effect for any period of 60 days; and (d) any failure by either party to perform any of the material covenants, conditions or obligations of this Agreement in any material respect if such a failure shall continue for a period of 90 days after delivery to the defaulting party, by another party, of a written notice specifying such failure in sufficient detail, unless such failure is not susceptible of being cured within such 90 day period and the defaulting party commences such cure within such period and diligently prosecutes said cure to completion.

9. Competitive Services. It is hereby acknowledged that Manager, Parent and their affiliated companies are currently in the business of developing, owning and operating surgical hospitals, ambulatory surgery centers and other health facilities and providing ambulatory surgery center management services to the public apart from the services that Manager will provide to the Company under this Agreement. Nothing in this Agreement shall prohibit Manager or any of its affiliated companies from owning and operating surgical hospitals, ambulatory surgery centers or other health facilities or from providing such management services. This Section 9 shall not affect any noncompetition or other covenant to which Manager is subject pursuant to any other agreement to which Manager (or its affiliate) is a party.

10. Assignment. Except as specifically provided in this Section 10, Manager shall not have the right to assign its rights or delegate its duties hereunder to any unrelated organization unless it first obtains the written consent of the Company. Manager may assign this Agreement without consent to (a) Parent, (b) a majority owned subsidiary of Parent,

(c) a partnership, corporation or other entity that directly or indirectly owns a majority of the outstanding equity securities of Manager or (d) another partnership, corporation or entity that is, concurrently with such assignment, succeeding to all of Manager's interest in the Company or to substantially all of the assets and liabilities of Manager. All of the terms, provisions, covenants, conditions and obligations of this Agreement shall be binding on and inure to the benefit of the successors and assigns of the parties hereto.

11. Notices. Except as otherwise expressly permitted herein, all notices, demands or requests required or permitted to be given hereunder shall be in writing and shall be deemed to have been properly given or served when personally delivered or, if mailed, when deposited in the United States mail, postage prepaid, registered or certified, return receipt requested, or by facsimile transmission (with a confirmation by registered or certified mail placed in the mail no later than the following business day), or by sending the same by a nationally recognized overnight delivery service. Unless changed by written notice given by either party to the other party pursuant hereto, such notices shall be given to the parties at the following addresses:

If to the Company:

_____, [LLC] [L.P.]
_____
_____
_____
Attention: Administrator
Facsimile No.: (___)___-____

If to Manager:

_____
_____
_____
_____
Attention: Administrator
Facsimile No.: (___)___-____

All notices, demands or requests by personal delivery or by facsimile transmission shall be effective and deemed served upon transmittal thereof. All notices, demands and requests sent by mail shall be effective and deemed served three days after being deposited in the United States mail. All notices, demands and requests sent by overnight delivery service shall be effective and deemed served on the day after being deposited with such overnight delivery service.

12. Attorneys' Fees. If any action at law or in equity is brought to enforce any of the terms of this Agreement, the prevailing party shall be entitled to reasonable attorneys' fees and costs in addition to any other relief, as determined by the applicable court.

13. **Entire Agreement.** This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes any and all prior agreements, either oral or written, between the parties with respect thereto.

14. **Enforceability.** In the event that any of the provisions of this Agreement are held to be invalid or unenforceable by any court of competent jurisdiction, the remaining provisions hereof shall not be affected thereby.

15. **Governing Law.** This Agreement shall be governed by and construed in accordance with _____ law, without regard to its conflicts of law principles.

16. **Counterparts; Execution.** This Agreement may be executed in multiple counterparts which, when taken together, shall constitute one instrument. Signatures transmitted by facsimile or via other electronic transmission system shall be accepted as original signatures.

17. **HIPAA Compliance.** The parties agree that, in order to comply with HIPAA, Manager and its affiliates shall meet all requirements and obligations contained in the Business Associate Exhibit attached hereto and incorporated herein by this reference.

18. **Amendments; Waiver.** This Agreement may be amended, modified, superseded or canceled, and any of the terms, provisions, covenants, representations, warranties or conditions hereof may be waived, only by a written instrument executed by the Company and Manager or, in the case of a waiver, by the party waiving compliance.

[Signatures on next page]

SUPPLEMENTAL #1
May 26, 2016
8:14 am

IN WITNESS WHEREOF, the parties hereto have executed this Management Agreement as of the day and year first above written.

USP _____, INC.

By _____
Name _____
Title _____

_____, [LLC] [L.P.]

By _____
Name _____
Title _____

SUPPLEMENTAL #1
May 26, 2016
8:14 am

Attachment B, Project Description, I

ValFund Description

SUPPLEMENTAL #1
May 26, 2016
8:14 am

About ValFund

Value Acquisition Fund is a private equity fund focused on commercial real estate acquisition and selective development. VAF creates single-purpose entities for each of its investments and may apply leverage depending on the transaction. In addition to stabilized assets, VAF will purchase assets that are vacant or in need of significant renovation and/or redevelopment. Because VAF was patient and restrained over the last decade of overheated acquisition activity, we are able to take advantage of the opportunities that are now presenting themselves.
Val Fund will respond quickly to any credible seller, doesn't waste a potential seller's time, and will not request additional information on a transaction if it is not a potential acquisition candidate.

Bio of Andrew F. Cates - Managing Member

Andy Cates is the Managing Member of Value Acquisition Fund, which he founded in 2004. He also serves as the General Partner and CEO of RVC Outdoor Destinations (www.rvcoutdoors.com), a related company that is focused on high-quality outdoor hospitality.

In 1999, Cates relocated to his hometown of Memphis, Tennessee to develop Soulsville (soulsvillefoundation.org), one of the largest inner city revitalization projects in the United States, as its Project Developer and founding Board Chairman. In the summer of 2000, Cates began working with a team of business and civic leaders to attract the Vancouver Grizzlies National Basketball Association franchise to Memphis, Tennessee, and to get public support for the team's arena (FedExForum). The "Pursuit Team" was successful in its efforts, and Cates became a member of the original local ownership group.

In 1996, Cates was a founding partner in Viceroy Investments, LLC. Viceroy has been the General Partner in over $150 Million of commercial real estate transactions. Cates focused the majority of his time from late 1996 to early 1998 repositioning and eventually selling the Lomas & Nettleton Corporate Campus that Viceroy purchased out of bankruptcy. Since 1998, Cates has continued his affiliation with Viceroy and is currently a partner in two Viceroy sponsored partnerships. Cates began his real estate career in Dallas, Texas, where he worked as an Analyst and later an Associate for Crow Investment Trust (now called Crow Family Holdings). At Crow, he was a member of a team responsible for partnership and loan workouts, office and industrial acquisitions, asset management, and commercial development.

Cates earned a Bachelor of Business Administration (Finance) degree at the University of Texas at Austin and was inducted into the Order of Omega National Honor Society and the Omicron Delta Kappa Leadership Society. In 2001, he was inducted into Lambda Alpha International, an honorary land economics society. In 2009, he was elected to the Board of Directors of Pioneer Natural Resources (NYSE:PXD) and re-elected to a second term in 2012. Pioneer was the best performing publicly traded energy company from 2009 – 2014. He also serves on the board of PICO Holdings (NASDAQ:PICO) and the Myelin Repair Foundation (myelinrepair.org), a leading medical research organization based in Saratoga, California. He and his wife Allison (former Audit Manager at Price Waterhouse) have very active twin children.

SUPPLEMENTAL #1
May 26, 2016
8:14 am

Our Guiding Principles.

1. We are value investors.
2. Debt does not drive any transaction. If an acquisition's unleveraged return looks average and the leveraged return looks extraordinary, the deal is average.
3. We will, to the best of our abilities, continue to choose and work with service providers and partners that share our value system and our investment philosophy. You can do a bad deal with a good partner but you cannot do a good deal with a bad partner.
4. We lose more sleep than our investors on anything we work on. A higher percentage of our total capital will be at risk than any of our investors'.
5. We are not, and will not be, fee driven.
6. Doing no transaction is better than doing a bad transaction. We are not deal junkies. We are long-term investors.
7. If we are attracted to an asset class or transaction in which we need additional local knowledge or industry-specific experience, we will find a partner we trust to share in the investment (assuming that the partner is expert in that asset class).
8. We will ask many questions and do exhaustive due diligence.
9. We will treat all parties with respect.
10. We will be honest and straightforward and avoid spin doctoring at all costs.

List of Recent Transactions

- **Greenbriar Holdings, LLC** – Single-family residential lot development in St. Johns County, Florida
- **Selva Capital, LLC** – $28 Million Acqisition & Development Loan for high-quality single-family residential development, Atlantic Beach, Florida
- **RVC Outdoor Destinations** – Multiple outdoor resort properties. RVC is the leading provider of high-quality outdoor hospitality in the United States. **http://www.rvcoutdoors.com/**
- **Jgalt, LLC** – multiple high quality residential lots (water and/or water views)
- **Rearden, LLC** – 118 acre land parcel, Lake Toxaway, North Carolina
- **Roark, LLC** – multiple land parcels

List of Other Projects

- **Lomas & Nettleton Corporate Campus** – Dallas, Texas

  Asset Class: Real Estate – Office
  Seller: United States Bankruptcy Court (Delaware)
  Buyer: Viceroy Partners, LP
  Property Size: 689,032 square feet (7 buildings)
  Transaction Size: $70 Million
  Purchase Date: August 1996
  Final Liquidation Date: February 1998

- **Denton Drive Service Center** – Dallas, Texas

Asset Class: Real Estate – Industrial/Service Center
Seller: Transcontinental Realty Investors, Inc
Buyer: Viceroy Delivery, LP
Property Size: 123,993 square feet
Transaction Size: $2.3 Million
Purchase Date: October 1998
Final Liquidation Date: N/A – owned by Viceroy Delivery, LP

- **Holiday Inn Select** – Love Field Airport, Texas

Asset Class: Real Estate – Hotel (full service)
Seller: 3300 Hotel Property, LP
Buyer: Mockingbird Partners, LP
Property Size: 244 Room, Full Service Hotel
Transaction Size: $15 Million
Purchase Date: October 2000
Final Liquidation Date: N/A – owned by Mockingbird Partners, LP

- **Pontotoc Place** – Memphis, Tennessee

Asset Class: Real Estate – Office
Seller: Rubikon, LLC
Buyer: Pontotoc Partners, LLC
Property Size: 35,000 square feet
Transaction Size: $2.5 Million
Purchase Date: July 2002
Final Liquidation Date: October 2003

- **The Centre at 8600** – Dallas, Texas

Asset Class: Real Estate Class A Office
(Class A Operations Center)
Seller: Wells Fargo
Buyer: Viceroy Partners II, LP
Property Size: 285,000 square feet (single story) on 20 acres
Transaction Size: Confidential
Purchase Date: July 2004
Final Liquidation Date: N/A, still owned

SUPPLEMENTAL #1
May 26, 2016
8:14 am

Attachment B, Project Description, III.A-4

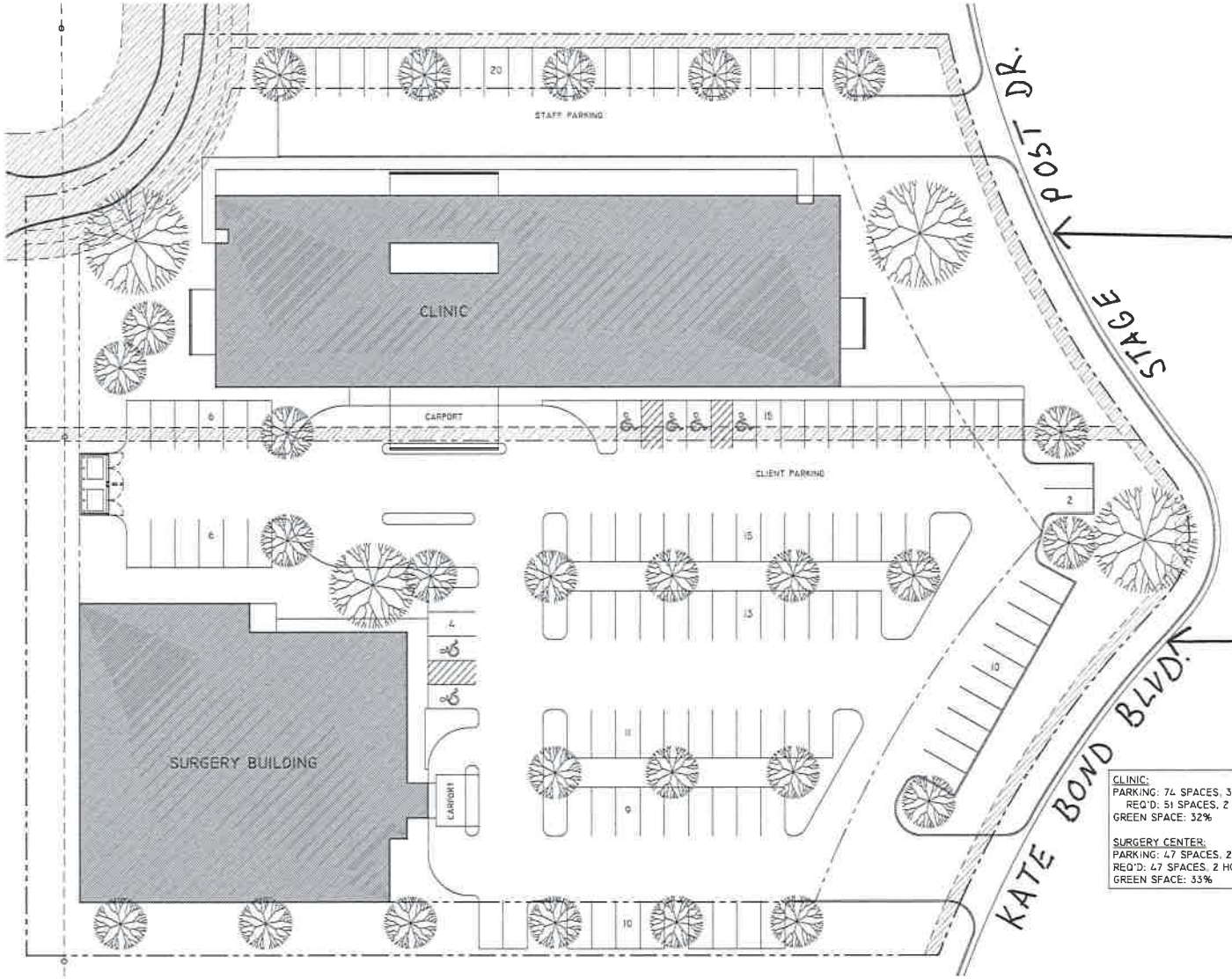
Plot Plan

archimania
356 south main
memphis, tn 38103

901.527.3560 p.
901.527.5018 f.
www.archimania.com

Not For Construction For Review Only

15320



CLINIC:
PARKING: 74 SPACES, 3-4 HC
REQ'D: 51 SPACES, 2 HC
GREEN SPACE: 32%

SURGERY CENTER:
PARKING: 47 SPACES, 2 HC
REQ'D: 47 SPACES, 2 HC
GREEN SPACE: 33%

Total acres: 2.91

P1 Site Plan

Tabor Orthopedics North

Bartlett, TN

Site Plan

May 26, 2016
8:14 am

SUPPLEMENTAL #1

09 MAY '16

PD

A0.1

P:\2015\15320 - Tabor Bartlett\Drawings\Plans\15320_FP01.dwg, A0.1, 5/10/2016 10:58:26 AM

SUPPLEMENTAL #1

May 26, 2016
8:14 am

Attachment C, Need, Item 4.A.

Revised Replacement Pages 27 and 28

service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

Response: Please see map included as Attachment C, Need-3. Both a county map and a zip code map are included to identify the proposed service area.

4. A. Describe the demographics of the population to be served by this proposal.

Response: Please see the information included below:

Current and Projected Population Change In Service Area by County

Shelby County			
Age	2016	2020	% Change
0 to 17	247,503	252,312	1.9
18+	711,858	728,710	2.4
65+	116,834	135,234	15.7
Total	959,361	981,022	2.3
Fayette County			
Age	2016	2020	% Change
0 to 17	9,670	10,014	3.6%
18+	34,967	38,496	10.1%
65+	8,731	11,171	27.9%
Total	44,637	48,510	8.7%
Tennessee			
Age	2016	2020	% Change
0 to 17	1,570,687	1,614,001	2.8
18+	5,241,318	5,494,030	4.8
65+	1,091,516	1,266,295	16.0
Total	6,812,005	7,108,031	4.3

Demographic Characteristics of Service Area by County

Demographic	Shelby County	Fayette County	Tennessee
Median Age – 2010 US Census	34.6	43.1	38.0
Age 65+ Population – 2016	116,834	8,731	1,091,516
% of Total Population	12.2%	19.6%	16.0%
Age 65+ Population – 2020	135,234	11,171	1,266,295
% of Total Population	13.8%	23.0%	17.8%
Median Household Income	$46,213	$55,623	$44,621
TennCare Enrollees (4/16)	276,265	7,202	1,525,548
Percent of 2016 Population Enrolled in TennCare	28.8%	16.1%	22.4%
Persons Below Poverty Level (2016)	220,653	6,472	1,246,597
Persons Below Poverty Level as % of Population (US Census)	23.0%	14.5%	18.3%

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans

of the facility will take into consideration the special needs of the service area population.

Response: The Bartlett ASC, LLC anticipates being readily accessible to the service area population and will serve the elderly, women, racial and ethnic minorities, and low include groups.

Demographic Characteristics of Service Area by County

Demographic	Shelby County	Fayette County	Tennessee
Median Age – 2010 US Census	34.6	43.1	38.0
Age 65+ Population – 2016	116,834	8,731	1,091,516
% of Total Population	12.2%	19.6%	16.0%
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Persons Below Poverty Level (2016)	220,653	6,472	1,246,597
Persons Below Poverty Level as % of Population (US Census)	23.0%	14.5%	18.3%

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response: There are no ASTCs existing in Bartlett, nor are there any that have been approved but are unimplemented. Bartlett is the 12th largest city in the State of Tennessee and the 2nd largest city in Shelby County. According to the Memphis Chamber of Commerce, Bartlett is one of the fastest growing suburbs in Shelby County. Based on U.S. Census data, Bartlett's population grew by 6.7% between 2010 and 2014, whereas Shelby County as a whole grew by only 1.1% during the same period. The only ASTC in the entire service area is North Surgery Center, located on the campus of Methodist North Hospital.

SUPPLEMENTAL #1
May 26, 2016
8:14 am

Attachment C, Economic Feasibility - 2

Funding Documentation

&

Revised Page 34

SUPPLEMENTAL #1
May 26, 2016
8:14 am

2. Identify the funding sources for this project.

Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

☒ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

☐ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

☐ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

☐ D. Grants--Notification of intent form for grant application or notice of grant award; or

☒ E. Cash Reserves--Appropriate documentation from Chief Financial Officer.

☐ F. Other—Identify and document funding from all other sources.

Response: The applicant will be receiving a commercial loan for part of the Project Costs. The applicant anticipates that it will receive cash from USPI in the amount of $2,000,000 and another $2,000,000 in cash when it syndicates the surgery center for a total of $4,000,000 in cash. The working capital amount will come from this cash amount. Any remaining amount of Project Costs is expected to be funded through a commercial loan. Please see a letter from the CFO for USPI indicating the cash is available and expected to be used for this project and a commercial loan letter indicating interest in financing the project, included as Attachment C, Economic Feasibility 2.

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

Response: The square footage will be 13,500 square feet. The cost per square foot for the new construction is anticipated to be $217.50 per square foot. The cost per square foot for the recent Southern Hills Surgery Center CON application was $360. Below is a chart showing the statewide cost per square foot for ASTCs from 2012-2014. The cost per square foot for the proposed ASTC is similar to that of other approved facilities or CON applications.

Ambulatory Surgical Treatment Center Construction Cost Per Square Foot 2012-2014

	Renovated Construction	New Construction	Total Construction
First Quartile	$0 / sq ft	$0 / sq ft	$133.55 / sq ft
Median	$0 / sq ft	$0 / sq ft	$150.00 / sq ft
Third Quartile	$0 / sq ft	$0 / sq ft	$174.88 / sq ft

Source: HSDA Construction Cost Per Square Foot Charts, 2012-2014.
Note: Insufficient sample size to calculate renovated and new construction ranges

4. Complete Historical and Projected Data Charts on the following two pages--***Do not modify the Charts provided or submit Chart substitutions!*** Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available for the institution. Projected Data Chart requests information

SUPPLEMENTAL #1

May 26, 2016
8:14 am

United Surgical Partners
INTERNATIONAL

May 23, 2016

Ms. Melanie Hill
Health Services and Development Agency
Andrew Jackson Building
502 Deaderick Street, 9th Floor
Nashville, TN 37219

Re: Certificate of Need Application CN1605-020, Bartlett ASC, LLC

Dear Mr. Earhart,

United Surgical Partners International, Inc. intends to fund its estimated $2,000,000 contribution to the Bartlett ASC, LLC project in Bartlett, Tennessee from cash on hand. USPI's financial information is reported as the Ambulatory Care segment included in the financial statements and information filed with the US Securities and Exchange Commission (the "SEC") by USPI's majority owner, Tenet Healthcare Corporation (NYSE:THC). Copies of those filings are available on the SEC's website at https://www.sec.gov/edgar/searchedgar/companysearch.html.

If you have any questions, please do not hesitate to contact our outside counsel on this matter, Kim H. Looney, of Waller Lansden Dortch & Davis, LLP.

Sincerely,

Jason Cagle, Chief Financial Officer
United Surgical Partners International, Inc.

SUPPLEMENTAL #1
May 26, 2016
8:14 am

Frost

777 Main Street
Fort Worth, Texas 76102

May 23, 2016

VIA EMAIL

Chris Suscha
Vice President, Development
United Surgical Partners International, Inc.
8 Cadillac Drive, Suite 200
Brentwood, Tennessee 37027
csuscha@uspi.com

Re: Preliminary indication of interest in providing financing to an ambulatory surgery center project in Bartlett, Tennessee

Dear Mr. Suscha,

I am writing to confirm Frost Bank's favorable conversations with United Surgical Partners International, Inc. regarding the development of an ambulatory surgery center with physician ownership in Bartlett, Tennessee (the "Project") and to express Frost Bank's initial interest in providing financing for the Project. As discussed, we currently anticipate that we would offer financing of an approximate aggregate principal amount of $3.1 million to the Project (the "Loan"). The anticipated terms of the Loan are currently expected to include a 90 month term and a fixed rate of interest of approximately 5.5%. The foregoing anticipated terms of the Loan are preliminary and subject to change, and do not reflect all of the material terms of the Loan which may be required by Frost Bank's underwriting requirements, which terms may include, without limitation, the grant of a security interest in some or all of the assets of the Project, certain affirmative and negative covenants, and other standard terms and conditions. Frost Bank's willingness to extend the Loan is further subject in its entirety to normal underwriting review and all necessary approvals.

Sincerely,

Clint Cockerell
Vice President, Frost Bank

SUPPLEMENTAL #1
May 26, 2016
8:14 am

Attachment C, Economic Feasibility - 3

Construction Cost Per Square Foot Charts

Ambulatory Surgical Treatment Center Construction Cost Per Square Foot

Years: 2013 – 2015

Due to insufficient sample size, Construction ranges are not available.

Hospital Construction Cost Per Square Foot

Years: 2013 – 2015

	Renovated Construction	New Construction	Total Construction
1st Quartile	$160.66/sq ft	$244.85/sq ft	$196.62/sq ft
Median	$223.91/sq ft	$308.43/sq ft	$249.67/sq ft
3rd Quartile	$297.82/sq ft	$374.32/sq ft	$330.50/sq ft

Source: CON approved applications for years 2013 through 2015

Nursing Home Construction Cost Per Square Foot

Years: 2013 – 2015

	Renovated Construction	New Construction	Total Construction
1st Quartile	$46.91/sq ft	$152.80/sq ft	$122.37/sq ft
Median	$90.00/sq ft	$172.14/sq ft	$152.80/sq ft
3rd Quartile	$101.01/sq ft	$185.00/sq ft	$172.14/sq ft

Source: CON approved applications for years 2013 through 2015

Outpatient Diagnostic Center Construction Cost Per Square Foot

Years: 2013 – 2015

Due to insufficient sample size, Construction ranges are not available.

As of 4/25/2016

Ambulatory Surgical Treatment Center Construction Cost Per Square Foot

Years: 2012 – 2014

	Renovated Construction	New Construction	Total Construction
1st Quartile	$0/sq ft	$0/sq ft	$113.55/sq ft
Median	$0/sq ft	$0/sq ft	$150.00/sq ft
3rd Quartile	$0/sq ft	$0/sq ft	$174.88/sq ft

Source: CON approved applications for years 2012 through 2014

Note: Insufficient sample size to calculate renovated and new construction ranges.

Hospital Construction Cost Per Square Foot

Years: 2012 – 2014

	Renovated Construction	New Construction	Total Construction
1st Quartile	$110.98/sq ft	$224.09/sq ft	$156.78/sq ft
Median	$192.46/sq ft	$259.66/sq ft	$227.88/sq ft
3rd Quartile	$297.82/sq ft	$296.52/sq ft	$298.66/sq ft

Source: CON approved applications for years 2012 through 2014

Nursing Home Construction Cost Per Square Foot

Years: 2012 – 2014

	Renovated Construction	New Construction	Total Construction
1st Quartile	$48.13/sq ft	$152.80/sq ft	$110.15/sq ft
Median	$70.26/sq ft	$170.48/sq ft	$152.80/sq ft
3rd Quartile	$101.00/sq ft	$185.00/sq ft	$174.53/sq ft

Source: CON approved applications for years 2012 through 2014

Outpatient Diagnostic Center Construction Cost Per Square Foot

Years: 2012 – 2014

Due to insufficient sample size, Construction ranges are not available.

SUPPLEMENTAL #1
May 26, 2016
8:14 am

Attachment C, Economic Feasibility - 4

Revised Projected Data Chart

SUPPLEMENTAL #1
May 26, 2016
8:14 am

PROJECTED DATA CHART

Give information for the two (2) years following the completion of this proposal. The fiscal year begins in January (Month).

		Year 2017	Year 2018
A.	Utilization Data (Cases)	1,985	3,217
B.	Revenue from Services to Patients		
1.	Inpatient Services	$ -	$ -
2.	Outpatient Services	6,378,033	9,341,653
3.	Emergency Services	-	-
4.	Other Operating Revenue (Specify) _____	-	-
	Gross Operating Revenue	$ 6,378,033	$ 9,341,653
C.	Deductions from Gross Operating Revenue		
1.	Contractual Adjustments	$ 750,632	$ 1,065,270
2.	Provision for Charity Care	55,000	82,000
3.	Provisions for Bad Debt	167,172	245,831
	Total Deductions	$ 972,804	$ 1,393,101
NET OPERATING REVENUE		$ 5,405,229	$ 7,948,552
D.	Operating Expenses		
1.	Salaries and Wages	$ 1,061,361	$ 1,352,415
2.	Physician's Salaries and Wages	-	-
3.	Supplies	1,395,618	2,330,441
4.	Taxes	164,469	164,469
5.	Depreciation	842,024	852,024
6.	Rent	387,964	387,964
7.	Interest, other than Capital	-	-
8.	Management Fees:		
a.	Fees to Affiliates	351,340	516,656
b.	Fees to Non-Affiliates	-	-
9.	Other Expenses – Specify on separate page 38	879,815	855,243
	Total Operating Expenses	$ 5,082,591	$ 6,593,264
E.	Other Revenue (Expenses) -- Net (Specify)_____	$ -	$ -
NET OPERATING INCOME (LOSS)		$ 322,638	$ 1,355,288
F.	Capital Expenditures		
1.	Retirement of Principal	$ 347,035	$ 366,611
2.	Interest	163,627	144,052
	Total Capital Expenditures	$ 510,662	$ 510,663
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES		$ (188,024)	$ 844,625

SUPPLEMENTAL #1
May 26, 2016
8:14 am

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year____	Year___	Year_____
1.	$	$	$
2.			
3.			
4.			
5.			
6.			
7.			
Total Other Expenses	$	$	$

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES		Year 2017	Year 2018
1.	Repairs and Maintenance	$ 186,000	$ 204,600
2.	Purchased Services	200,000	206,000
3.	Minor Equipment	50,000	51,250
4.	Utilities	135,000	138,375
5.	Non-Medical Supplies and Expenses	225,000	153,750
6.	Professional Fees	50,000	51,250
7.	Sales Expense	10,000	10,250
8.	Insurance	23,815	39,768
	Total Other Expenses	$ 879,815	$ 855,243

SUPPLEMENTAL #1

May 26, 2016
8:14 am

Attachment C, Contribution to the Orderly Development Of Health Care

Publication Affidavit

SUPPLEMENTAL #1

May 26, 2016
8:14 am

The Commercial Appeal
Affidavit of Publication

STATE OF TENNESSEE
COUNTY OF SHELBY

Personally appeared before me, Patrick Maddox, a Notary Public, Helen Curl, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached advertisement was published in the following editions of The Commercial Appeal, to-wit:

May 10, 2016

Helen Curl

Subscribed and sworn to before me this 10th day of May, 2016.

Notary Public

My commission expires January 20, 2020.

PATRICK MADDOX
STATE OF TENNESSEE
NOTARY PUBLIC
COUNTY OF SHELBY

SUPPLEMENTAL #1

May 26, 2016
8:14 am

Attachment C, Contribution to the Orderly Development Of Health Care

Project Completion Forecast Chart

SUPPLEMENTAL #1

May 26, 2016

8:14 am

PROJECT COMPLETION FORECAST CHART

Enter the Agency projected Initial Decision date, as published in TCA § 68-11-1609(c): August 24, 2016

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase		DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1.	Architectural and engineering contract signed	21	9/16
2.	Construction documents approved by the Tennessee Department of Health	65	12/16
3.	Construction contract signed	14	12/16 – 1/17
4.	Building permit secured	14	12/16
5.	Site preparation completed	30	1/17
6.	Building construction commenced	30	1/17
7.	Construction 40% complete	90	4/17
8.	Construction 80% complete	180	7/17
9.	Construction 100% complete (approved for occupancy	224	9/17
10.	*Issuance of license	15	10/17
11.	*Initiation of service	0	10/17
12.	Final Architectural Certification of Payment	30	11/17
13.	Final Project Report Form (HF0055)	0	11/17

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

SUPPLEMENTAL #1
May 26, 2016
8:14 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: UNITED SURGICAL PARTNERS INTERNATIONAL

I, KIM LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Kim H. Looney
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 25th day of May, 2016, witness my hand at office in the County of Davidson, State of Tennessee.

Carmen M. Salazar
NOTARY PUBLIC

My commission expires _____, _____.

CARMEN M. SALAZAR
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON
MY COMMISSION EXPIRES: JULY 8, 2017

HF-0043

Revised 7/02

4823-6441-9377.7

Supplemental #2
-Original-

Bartlett ASC LLC

CN1605-020

SUPPLEMENTAL #2

May 31, 2016
11:44 am

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, TN 37219-8966

615.244.6380 main
615.244.6804 fax
wallerlaw.com

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

May 31, 2016

VIA HAND DELIVERY
Phillip M. Earhart
Health Services Development Examiner
Andrew Jackson Bldg - 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: Certificate of Need Application CN1605-020
Bartlett ASC, LLC

Dear Mr. Earhart:

In response to your request for additional information, please see the following responses.

1. **Section A, Item 6**

The response to this item is noted. Please provide a fully executed Option to Lease (signed by both parties) that at least includes the name of the landlord, the expected term of the lease and the anticipated lease payments.

Please provide documentation that ValFund has a deed to the property.

RESPONSE: Please see attached an Option to Lease executed by both parties. The land is currently owned by Magnolia Gardens, Inc. and Camellia Gardens, Inc. Richard D. Austin, Jr. is the Secretary/Treasurer of these legal entities and is authorized to sign on their behalf. Mr. Austin and some investors (to be named) will form a single purpose LLC that will have a lease with the applicant for the site and building. The real estate will be contributed to the single purpose LLC by Magnolia Gardens, Inc. and Camellia Gardens, Inc. and/or its assigns. It is the to be formed single purpose LLC that will obtain a commercial loan for the development of the ASTC building. The applicant has no information as to debt structure or any financials because it is not a part of the entity that will be obtaining the funding, or developing the project. ValFund will be the developer of the project, but will be doing so pursuant to payment of a development fee, and not as the entity obtaining the commercial loan, as previously disclosed. It is the applicant's understanding that many of the details cannot be determined, unless and until the application is approved. The Option to Lease and the deed for the property are included as Attachment A, 6.

2. Section C, Economic Feasibility, Project Costs Chart

Please list any equipment over $50,000 in cost.

RESPONSE: Please see the list below which identifies the equipment to be purchased that is over $50,000 per item.

	Room Name	Description		Unit Cost
1	Specialty - Spine	Microscope, Neuro / Spine, Allowance	$	148,000.00
2	Procedure Room	X-Ray, C-Arm, 9", 9900 Digital Elite, w/ Printer	$	134,196.00
3	Specialty - Orthopedic	X-Ray, C-Arm, 9", 9900 Digital Elite, w/ Printer	$	134,196.00
4	Assembly / Make Up	Sterilizer, Low Temp	$	130,574.22
5	Assembly / Make Up	Sterilizer, Integral Boiler, Evolution 37x37x42	$	126,663.72
6	Specialty - Spine	OR table, Jackson, OSI 5085, w/ Wilson Frame	$	101,301.20
7	Specialty - Total Joints	Table, HANA, OSI	$	99,764.35
8	Decontamination	Washer Disinfector, Single-Chamber	$	77,862.31
9	Specialty - Orthopedic	Mini C-Arm, Hands and Podiatry	$	71,600.00
10	Assembly / Make Up	Sterilizer, Integral Boiler, Recessed 20x20x38	$	56,184.87
11	Specialty - Spine	Drill, Midas Rex	$	50,000.00

3. Economic Feasibility, Item 2, Project Funding

It is noted the applicant will receive $4,000,000 in cash and up to a 3.1M loan. However, there appears to be a balance of $54,506.40 that is not funded. Please clarify.

RESPONSE: The costs on the Project Costs Chart that need to be funded are the following:

Legal, Administrative Consultant Fees	$ 200,000
Moveable Equipment	3,002,412
Tenant Improvements	2,901,353

Working Capital	650,000
CON Filing Fee	22,085.48
TOTAL	$ 6,755, 850.48

The other expenses listed are the pre-opening expenses, which are included in the working capital, as indicated in the application, and the lease of the facility, which is not financed, but paid out of current operating revenues.

4. Section C, Economic Feasibility, Item 9

It is noted the applicant calculated Medicare % of total revenues in Year One from the original Projected Data Chart. Please complete the following chart for Year One of the proposed project using revised gross charges (that includes charity care and contractual adjustments) from the revised Projected Data Chart

Payor	Gross Revenue	% of Total Revenues
Medicare	$668,688	10.5

Very truly yours,

Kim H. Looney

KHL:mk
Enclosures

SUPPLEMENTAL #2
May 31, 2016
11:44 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: BARTLETT ASC, LLC

I, KIM LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title
KIM H. LOONEY, ATTORNEY

Sworn to and subscribed before me, a Notary Public, this the 31st day of May, 2016, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires _____, _____.

CARMEN M. SALAZAR
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON
MY COMMISSION EXPIRES: JULY 3, 2017

HF-0043

Revised 7/02

SUPPLEMENTAL #2
May 31, 2016
11:44 am

ATTACHMENT A, 6,

OPTION TO LEASE and DEED TO PROPERTY

OPTION TO LEASE AGREEMENT

THIS OPTION TO LEASE AGREEMENT (the "Agreement") is made and entered into as of this _____ day of May 2016, by and between a to be formed single purpose limited liability company ("Landlord") and Bartlett ASC, LLC, a Tennessee limited liability company ("Tenant").

WITNESSETH

WHEREAS, Landlord has plans to construct a building located at 0 Kate Bond Boulevard, Bartlett (address to be assigned) in Shelby County, Tennessee (the "Property"); and

WHEREAS, the land on which the building is to be developed is owned by Magnolia Gardens, Inc. and Camellia Gardens, Inc., which land will be contributed to the single purpose LLC; and

WHEREAS, Landlord desires to enter into an option with Tenant whereby Landlord grants to Tenant the option to lease approximately 13,500 square feet of the Property (the "Leased Premises"), which option must be exercised as set forth below.

NOW, THEREFORE, for $10 cash in hand paid and in consideration of the mutual promises set forth herein and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

SECTION 1
GRANT OF OPTION

1.1 Landlord hereby grants to Tenant an exclusive option to lease the Leased Premises, upon the terms and conditions set forth herein (the "Option").

1.2 The term of Tenant's Option shall commence on the date hereof and shall continue for a period of six (6) months from the date hereof (the "Option Period"). The Option Period may be extended at any time prior to its expiration upon the mutual consent of the parties.

1.3 Tenant shall exercise its Option by delivering written notice to Landlord within the Option Period by Registered or Certified Mail, or in person.

1.4 Notwithstanding the foregoing, the Option shall automatically terminate if Tenant is not successful in obtaining a Certificate of Need to establish an ambulatory surgical treatment center from the State of Tennessee Health Services and Development Agency at the Leased Premises which is not subject to a contested case hearing on or before September 24, 2016.

SECTION 2
TERMS AND CONDITIONS OF THE LEASE

2.1 Upon the exercise of the Option by Tenant as set forth herein, the parties agree to execute a formal lease agreement, subject to any terms and conditions contained in this Agreement and as mutually agreed upon by the parties. The parties expect that rent shall reflect the fair market value of the property and shall be approximately $30.00 per square foot, although an exact amount will not be determined until the final costs for the development and construction of the building are known.

2.2 The initial term of Tenant's lease of the Leased Premises shall be for a period of ten (10) years (the "Term").

SECTION 3
MISCELLANEOUS PROVISIONS

3.1 Any notices required or permitted herein shall be addressed as follows and delivered to the other party by either registered or certified mail, facsimile, or in person:

If to Landlord:

Richard D. Austin, Jr.
1892 Hunters Hill Drive
Germantown, Tennessee 38138

If to Tenant:

Bartlett ASC, LLC
c/o USP Tennessee, Inc.
15305 Dallas Parkway
Suite 1600
Addison, TX 75001
Attention: Chief Legal Officer

With a copy to:

United Surgical Partners International, Inc.
15305 Dallas Parkway
Suite 1600
Addison, TX 75001
Attn: James Bowden, Senior Corporate Counsel, Development

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by such party, as of the date first above written.

LANDLORD:

By:_____
Richard D. Austin, Jr., Authorized Signatory

TENANT:

Bartlett ASC, LLC

By: USP Tennessee, Inc., its Sole Member

By:_____
Name: Corey Ridgway/ Erik Kraemer
Its: Vice President

17084274.2

4829-9256-0945.9

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by such party, as of the date first above written.

LANDLORD:
To be Formed Special Purpose Entity

By: Richard D. Austin, Jr.
Title: _____

TENANT:
Bartlett ASC, LLC

By: USP Tennessee, Inc., Sole Member of Bartlett ASC, LLC
Name: _____
Title: _____

WARRANTY DEED

DF 7453

This Instrument Prepared By and Return To:	Send Tax Bills To:	Map Parcel No.:
Evans & Petree By: Paul F.T. Edwards 81 Monroe Avenue Memphis, Tennessee 38103	Camellia Gardens, Inc. 204 Windover, #17 Memphis, TN 38111	B1 581B-1

THIS INDENTURE made and entered into this 15th day of December, 1992, by and between B.I.P., LTD., a Tennessee limited partnership, party of the first part, and CAMELLIA GARDENS, INC., a Tennessee corporation and MAGNOLIA GARDENS, INC., a Tennessee corporation, each an undivided one-half interest, party of the second part,

WITNESSETH: That for and in consideration of Ten Dollars ($10.00) cash in hand paid, and other good and valuable consideration, the receipt of all of which is hereby acknowledged, the said party of the first part has bargained and sold and does hereby bargain, sell, convey and confirm unto the said party of the second part the following described real estate situated and being in Shelby County, Tennessee:

Lot 6, Phase 2, Bartlett Corporate Park East Subdivision, consisting of approximately 1.7 acres, as shown on plat of record in Plat Book 138, Page 36, in the Register's Office of Shelby County, Tennessee, to which plat reference is hereby made for a more particular description of said property.

Being part of the same property conveyed to party of the first part by Quit Claim Deed of record at Instrument No. Z2 1556 in the Register's Office of Shelby County, Tennessee.

TO HAVE AND TO HOLD the aforesaid real estate, together with all the appurtenances and hereditaments thereunto belonging or in any wise appertaining unto the said party of the second part, its heirs, successors and assigns in fee simple forever.

And the said party of the first part does hereby covenant with the said party of the second part that it is lawfully seized in fee of the aforedescribed real estate, that it has a good right to sell and convey the same; that the same is unencumbered except for subdivision restrictions, building lines and easements of record in Plat Book 138, Page 36, Declaration of Covenants of record at Instrument No. AG 2532, Amended and Restated Operation and Reciprocal Easement Declaration at Instrument No. CV 3256, all of record in the Register's Office of Shelby County, Tennessee, and 1993 City of Bartlett taxes not yet due and payable, and 1993 Shelby County taxes not yet due and payable, and that the title and quiet possession thereto it will warrant and forever defend against the lawful claims of all persons.

The word "party" as used herein shall mean "parties" if more than one person or entity be referred to, and pronouns shall be construed according to their proper gender and number according to the context hereof.

WITNESS the signature of the said party of the first part the day and year first above written.

B.I.P., LTD., a Tennessee
limited partnership

By: Elwood L. Edwards
Elwood L. Edwards, General Partner

ACKNOWLEDGEMENT

DF 7453

STATE OF TENNESSEE
COUNTY OF SHELBY

Before me, a Notary Public of said State and County aforesaid, personally appeared ELWOOD L. EDWARDS, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who, upon oath, acknowledged himself to be a general partner of B.I.P., LTD., the within named bargainor, a Tennessee limited partnership, and that he as such general partner, executed the foregoing instrument for the purposes therein contained, by signing the name of the limited partnership by himself as general partner.

WITNESS my hand and seal this 15th day of December, 1992.

Notary Public

My Commission expires:

_____

Property Address:

Vacant Land

State Tax	$444.00
Register's Fee	$1.00
Recording Fee	$15.00
Total	$460.00

DF7453

I, or we, hereby swear or affirm that, to the best of affiant's knowledge, information and belief, the actual consideration for this transfer or value of the property transferred, whichever is greater, is $120,000.00, which amount is equal to or greater than the amount which the property transferred would command at a fair and voluntary sale.

Elizabeth Weeks Crews, agent
Affiant

Subscribed and sworn to before me this 15th day of December, 1992.

Notary Public

My Commission expires:
8-26-96

DF 7453
12-24
120,000
444.00
1.00
15.00
460.00
SUE D. BAYNE

RETURN TO:
SCHNEIDER & ROBINSON
6363 POPLAR SUITE 101
MEMPHIS, TN 38119

92.458

Original

ADDITIONAL INFORMATION

Bartlett ASC, LLC

CN1605-020

waller

Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
Nashville, TN 37219-8966

615.244.6380 main
615.244.6804 fax
wallerlaw.com

Kim Harvey Looney
615.850.8722 direct
kim.looney@wallerlaw.com

June 21, 2016

VIA HAND DELIVERY
Phillip M. Earhart
Health Services and Development Agency
Andrew Jackson Bldg - 9th Floor
502 Deaderick Street
Nashville, TN 37243

Re: Certificate of Need Application CN1605-020
Bartlett ASC, LLC - Establishment of a Specialty Ambulatory Surgical Center in Bartlett, Shelby County, Tennessee

Dear Phillip:

In response to your request for additional information, please find the fully executed Option to Lease Agreement and Contribution Agreement.

If you have any questions, please contact me at 615-850-8722 or by email at Kim.Looney@wallerlaw.com.

Very truly yours,

Kim H. Looney

KHL:lg
Enclosures

OPTION TO LEASE AGREEMENT

THIS OPTION TO LEASE AGREEMENT (the "Agreement") is made and entered into as of this _____ day of June 2016, by and between SC Property Partners, LLC ("Landlord") and Bartlett ASC, LLC, a Tennessee limited liability company ("Tenant").

WITNESSETH

WHEREAS, Landlord has plans to construct a building located at 0 Kate Bond Boulevard, Bartlett (address to be assigned) in Shelby County, Tennessee (the "Property"); and

WHEREAS, the land on which the building is to be developed is owned by Magnolia Gardens, Inc. and Camellia Gardens, Inc., which land will be contributed to SC Property Partners, LLC after the certificate of need referenced below is granted; and

WHEREAS, Landlord desires to enter into an option with Tenant whereby Landlord grants to Tenant the option to lease approximately 13,500 square feet of the Property (the "Leased Premises"), which option must be exercised as set forth below.

NOW, THEREFORE, for $10 cash in hand paid and in consideration of the mutual promises set forth herein and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

SECTION 1
GRANT OF OPTION

1.1 Landlord hereby grants to Tenant an exclusive option to lease the Leased Premises, upon the terms and conditions set forth herein (the "Option").

1.2 The term of Tenant's Option shall commence on the date hereof and shall continue for a period of six (6) months from the date hereof (the "Option Period"). The Option Period may be extended at any time prior to its expiration upon the mutual consent of the parties.

1.3 Tenant shall exercise its Option by delivering written notice to Landlord within the Option Period by Registered or Certified Mail, or in person.

1.4 Notwithstanding the foregoing, the Option shall automatically terminate if Tenant is not successful in obtaining a Certificate of Need to establish an ambulatory surgical treatment center from the State of Tennessee Health Services and Development Agency at the Leased Premises which is not subject to a contested case hearing on or before October 26, 2016.

SECTION 2
TERMS AND CONDITIONS OF THE LEASE

2.1 Upon the exercise of the Option by Tenant as set forth herein, the parties agree to execute a formal lease agreement, subject to any terms and conditions contained in this Agreement and as mutually agreed upon by the parties. The parties expect that rent shall reflect the fair market value of the property and shall be approximately $30.00 per square foot, although an exact amount will not be determined until the final costs for the development and construction of the building are known.

2.2 The initial term of Tenant's lease of the Leased Premises shall be for a period of ten (10) years (the "Term").

SECTION 3
MISCELLANEOUS PROVISIONS

3.1 Any notices required or permitted herein shall be addressed as follows and delivered to the other party by either registered or certified mail, facsimile, or in person:

If to Landlord:

Richard D. Austin, Jr.
1892 Hunters Hill Drive
Germantown, Tennessee 38138

If to Tenant:

Bartlett ASC, LLC
c/o USP Tennessee, Inc.
15305 Dallas Parkway
Suite 1600
Addison, TX 75001
Attention: Chief Legal Officer

With a copy to:

United Surgical Partners International, Inc.
15305 Dallas Parkway
Suite 1600
Addison, TX 75001
Attn: James Bowden, Senior Corporate Counsel, Development

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by such party, as of the date first above written.

LANDLORD:

SC Property Partners, LLC

By: _____
Name: Richard D. Austin, Jr. Authorized Signatory

TENANT:

Bartlett ASC, LLC

By: USP Tennessee, Inc., its Sole Member

By: _____
Name: Corey Ridgway
Its: Vice President

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by such party, as of the date first above written.

LANDLORD:

SC Property Partners, LLC

By: _____
Name: Richard D. Austin, Jr. Authorized Signatory

TENANT:

Bartlett ASC, LLC

By: USP Tennessee, Inc., its Sole Member

By: _____
Name: Corey Ridgway
Its: Vice President

CONTRIBUTION AGREEMENT

THIS CONTRIBUTION AGREEMENT (the "Agreement") is made and entered into as of this _____ day of June 2016, by and between SC Property Partners, LLC ("SC Property") and Richard D. Austin, authorized signatory of Magnolia Gardens, Inc. and Camellia Gardens, Inc. ("Austin").

WITNESSETH:

WHEREAS, SC Property has plans to construct a building located at 0 Kate Bond Boulevard, Bartlett (address to be assigned) in Shelby County, Tennessee (the "Property"); and

WHEREAS, SC Property has entered into an Option to Lease Agreement with Bartlett ASC, LLC to lease approximately 13,500 square feet of the Property (the "Leased Premises"); and

WHEREAS, the land on which the building is to be developed (the "Land") is owned by Magnolia Gardens, Inc. and Camellia Gardens, Inc., which Land will be contributed to SC Property after the certificate of need referenced below is granted; and

NOW, THEREFORE, for $10 cash in hand paid and in consideration of the mutual promises set forth herein and other valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

SECTION 1
CONTRIBUTION OF LAND

1.1 Austin hereby agrees to contribute the Land to SC Property, upon the terms and conditions set forth herein (the "Contribution").

1.2 Notwithstanding the foregoing, the Contribution is contingent on Bartlett ASC, LLC successfully obtaining a Certificate of Need to establish an ambulatory surgical treatment center from the State of Tennessee Health Services and Development Agency at the Leased Premises which is not subject to a contested case hearing on or before October 26, 2016.

SECTION 2
MISCELLANEOUS PROVISIONS

2.1 Any notices required or permitted herein shall be addressed as follows and delivered to the other party by either registered or certified mail, facsimile, or in person:

If to SC Property:

Attention: Richard D. Austin, Jr.
1892 Hunters Hill Drive
Germantown, Tennessee 38138

If to Magnolia Gardens, Inc. and Camellia Gardens, Inc.:

Attention: Richard D. Austin, Jr.
1892 Hunters Hill Drive
Germantown, Tennessee 38138

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by such party, as of the date first above written.

SC PROPERTY:

SC Property Partners, LLC

By: _____
Name: Richard D. Austin, Jr., Authorized Signatory

Member: Magnolia Gardens, Inc. and Camellia Gardens, Inc.

By: _____
Name: Richard D. Austin, Jr., Authorized Signatory

17866056.2

4839-7413-0739.2

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY: BARTLETT ASC, LLC

I, KIM LOONEY, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title
KIM H. LOONEY, ATTORNEY

Sworn to and subscribed before me, a Notary Public, this the 21st day of June, 2016, witness my hand at office in the County of Davidson, State of Tennessee.

NOTARY PUBLIC

My commission expires January 8, 2019.

LAURIE A. GLASS
STATE OF TENNESSEE NOTARY PUBLIC
COUNTY OF DAVIDSON
MY COMMISSION EXPIRES: JANUARY 8, 2019

HF-0043

Revised 7/02